

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1514

CERTIFICATE OF DEATH

01493

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 107 A. Central Ave.		d. STREET ADDRESS 107 A. Central Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Howard Middle Vernon Last Abbott		4. DATE OF DEATH Month Feb. Day 25 , Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1896
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min.	11. IF UNDER 24 HRS. Months 65 Days 65 Hours 65 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman on Railroad		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Abbott		14. MOTHER'S MAIDEN NAME Nina Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Edna M. Abbott		Address Glyndon, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) none (c) none			INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive C-V Disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m. none		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 11-24-52 , 19__, to 2-25-61 , 19__, that I last saw the deceased alive on 2-11-61 , 19__, and that death occurred at 4 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Road DATE SIGNED 2-27-61 ACTUAL SIGNATURE D. D. Caples M.D. PHYSICIAN'S NAME (Type) D. D. Caples, M. D. Reisterstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 28, 1961	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens		22d. LOCATION (City, town, or county) (State) Finksburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons		24a. REC'D BY REGISTRAR FEB 28 '61	
ADDRESS Reisterstown, Md.		24b. REGISTRAR'S SIGNATURE Carlton J. Harris	

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1. PLACE OF DEATH a. COUNTY <u>Balto.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>		c. LENGTH OF STAY IN 1b <u>Fullerton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 412 Babikow Rd.</u>		d. STREET ADDRESS <u>Box 412 Babikow Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nellie R. Adams</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 17, 1899</u>	
9. AGE (In years lost birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Thomas Tyree</u>		14. MOTHER'S MAIDEN NAME <u>Queen Drumheller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name; unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Fred Adams</u>		Address <u>Box 412 Babikow Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO <u>4-20-61</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Arterio-sclerotic heart disease</u> <u>nephrosclerosis with hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 year</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-18-1960</u> to <u>2-20-1961</u> , that (I) (we) last saw the deceased alive on <u>2-11-1961</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Wyman K Wong</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>WYMAN K WONG</u>		22d. ADDRESS <u>6801 Belair Rd 6 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-25-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian</u>		23d. LOCATION (City, town, or county) (State) <u>Lynchburg, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Carroll Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 23 '61</u>	
ADDRESS <u>7401 Belair Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1516 CERTIFICATE OF DEATH 01495											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>301 West Chesapeake Avenue</u> (Towson Conv. Home)						d. STREET ADDRESS <u>2009 E. 32nd Street</u>					
3. NAME OF DECEASED (Type or print) <u>Mrs. Mary Carroll Albrecht</u>						4. DATE OF DEATH <u>February 22nd 1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 18, 1880</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Ransom Carroll</u>						14. MOTHER'S MAIDEN NAME <u>Ella B. Street</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or date of service)</u>						17. INFORMATION <u>Mr. R. Carroll Albrecht 1525 Pentridge</u>					
16. SOCIAL SECURITY NO.						17. INFORMATION <u>Mr. R. Carroll Albrecht 1525 Pentridge</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.1</u> DUE TO <u>Decompensative Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED Whirl at work <input type="checkbox"/> Not Whirl at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Jan 10, 1960</u> to <u>Feb 22, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 22, 1961</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Laurence C. Post</u>						22b. DATE <u>2/22/61</u>		22c. PHYSICIAN'S NAME (Type) <u>LAURENCE C. Post</u>			
22d. ADDRESS <u>6805 York Rd</u>						22e. ADDRESS <u>6805 York Rd</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/24/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>						25a. REC'D BY REGISTRAR <u>FEB 27 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

[Faint handwritten notes]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1517

CERTIFICATE OF DEATH

Item 7 Filed 2-20-61 at

01496

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Holly Hill Manor		d. STREET ADDRESS 5500 Ivanhoe Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Maurice Middle Mosby Last Allen		4. DATE OF DEATH Month February Day 5 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1875
9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 8 Days 5 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Salesman		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Oxford, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Allen		14. MOTHER'S MAIDEN NAME Annie Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 221-09-6833	
17. INFORMANT Mrs. Glen Baer		Address 5500 Ivanhoe Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial failure DUE TO Arteriosclerosis (generalized) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 days DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute pulmonary edema = ascites			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 21, 1959 to Feb. 5, 1961 , that (I) (we) last saw the deceased alive on Feb. 5, 1961 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE H.V. Harbold		22b. DATE SIGNED 2/7/61	
22c. PHYSICIAN'S NAME (Type) H.V. HARBOLD		22d. ADDRESS 4706 Harford Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/8/1961	
23c. NAME OF CEMETERY OR CREMATORY Windy Hill Cemetery		23d. LOCATION (City, town, or county) (State) Windy Hill, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR 4905 York Road	
25b. REGISTRAR'S SIGNATURE Baltimore 12, Md.		25c. DATE FEB 8 '61	

1513

CENTRAL AIR LINE

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THE
CENTRAL AIR LINE
IS A
NEW
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IMPROVED
METHOD
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PASSENGERS
AND
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AIR
PLANE
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TRUCK
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RAILROAD
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SHIP
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BOAT
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CARRIAGE
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HORSE
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DONKEY
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CATTLE
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AND
JEWELS

CERTIFICATE OF DEATH

Reg. Dist. No.

01497

1518

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney, Md		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9622 Dixon Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jacob D. Aughenbaugh.		4. DATE OF DEATH February 24, 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 14, 1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handy Man		10b. KIND OF BUSINESS OR INDUSTRY Good Will	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Elmer Lohr. 9622 Dixon Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POSTERIOR MYOCARDIAL INFARCT DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420.1 (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE DUE TO ESSENTIAL HYPERTENSION (c) 10 days 8 YRS 12 YRS 15 YRS		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/28 19 49 to 2/24 19 61 , that I last saw the deceased alive on 2/21 19 61 , and that death occurred at 9:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Hirschfeld M.D.		ADDRESS (Street, city or town, state) 6919 HARFORD ROAD	
PHYSICIAN'S NAME (Type) JOHN H. HIRSCHFELD M.D.		DATE SIGNED BALTIMORE 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Shipment	22b. DATE THEREOF 2/27/61	22c. NAME OF CEMETERY OR CREMATORY Rose Hill	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Justin E. Donovan-3818 Roland Ave		24a. REC'D BY REGISTRAR FEB 28 '61	24b. REGISTRAR'S SIGNATURE Colman E. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE OF TEXAS

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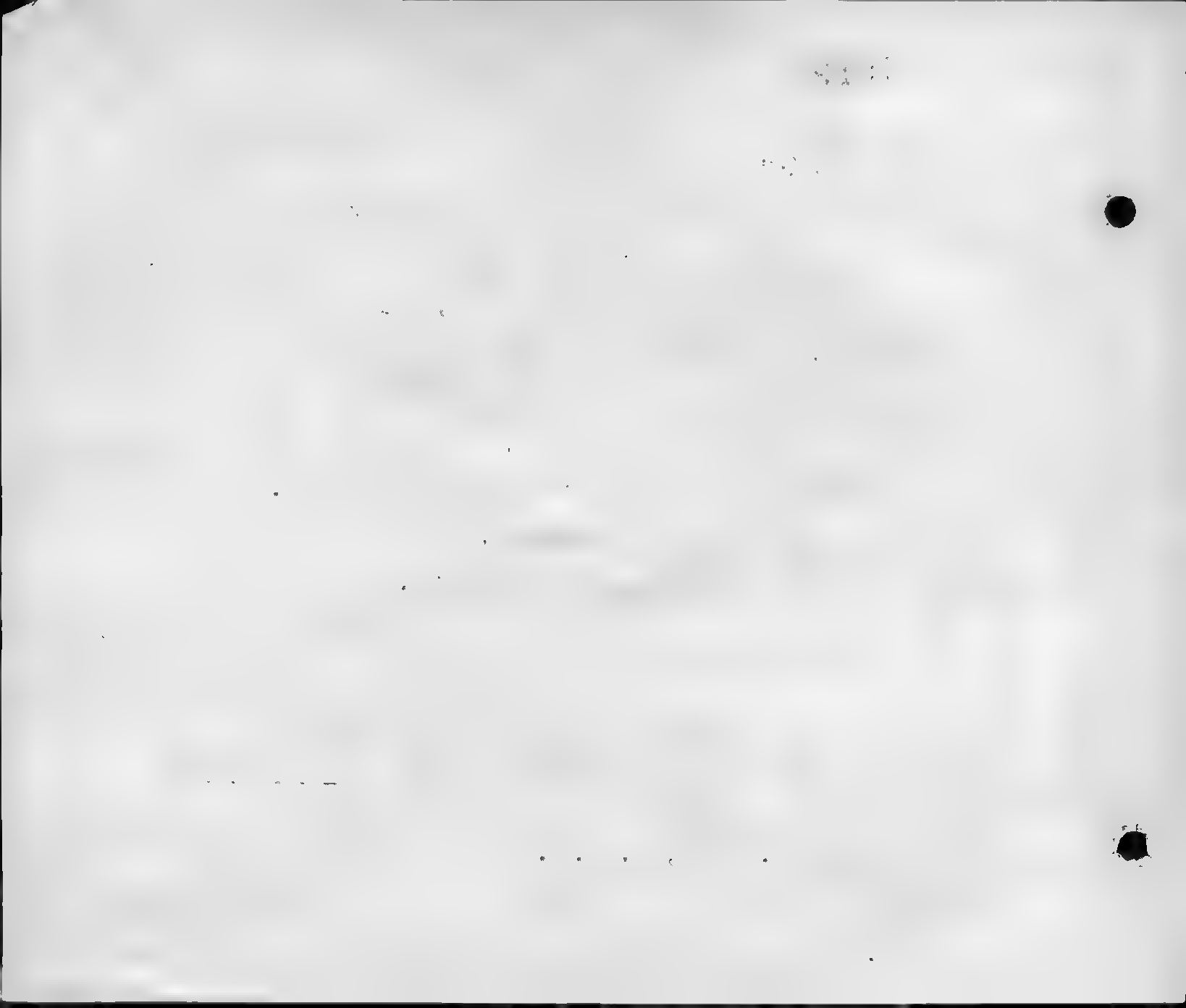
County

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 1 Film G282 2-2-61											
01498											
1. PLACE OF DEATH a. COUNTY		BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		MARYLAND		b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Bradshaw		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		BRADSHAW		d. STREET ADDRESS Bradshaw Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		At home								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
5. SEX		Male		6. COLOR OR RACE		White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
										9. AGE (in years last birthday)	
										57 yrs.	
										10. IF UNDER 1 YEAR Months Days	
										11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Guns and Amm.		Wholesale		Peoria, Illinois		USA					
13. FATHER'S NAME		Halsey Bellwood		14. MOTHER'S MAIDEN NAME		Zelda Zbindin					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
				Mrs. Stefania Bellwood		same					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Arteriosclerotic Cardiovascular disease.							
420		18000									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Myocardial infarction.							
		18000									
		(c)		Carbon Monoxide Intoxication.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		William V. Lovitt, Jr., M. D.		M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED February 23, 1961	
22a. BURIAL, CREMATION, or other disposition		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country)				(State)	
Burial		2/27/61		Green Mount Cemetery		Baltimore, Maryland					
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Leonard J. Ruck		5305 Hartford Road #14		DATE FEB 27 '61		Arthur S. Kraus					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

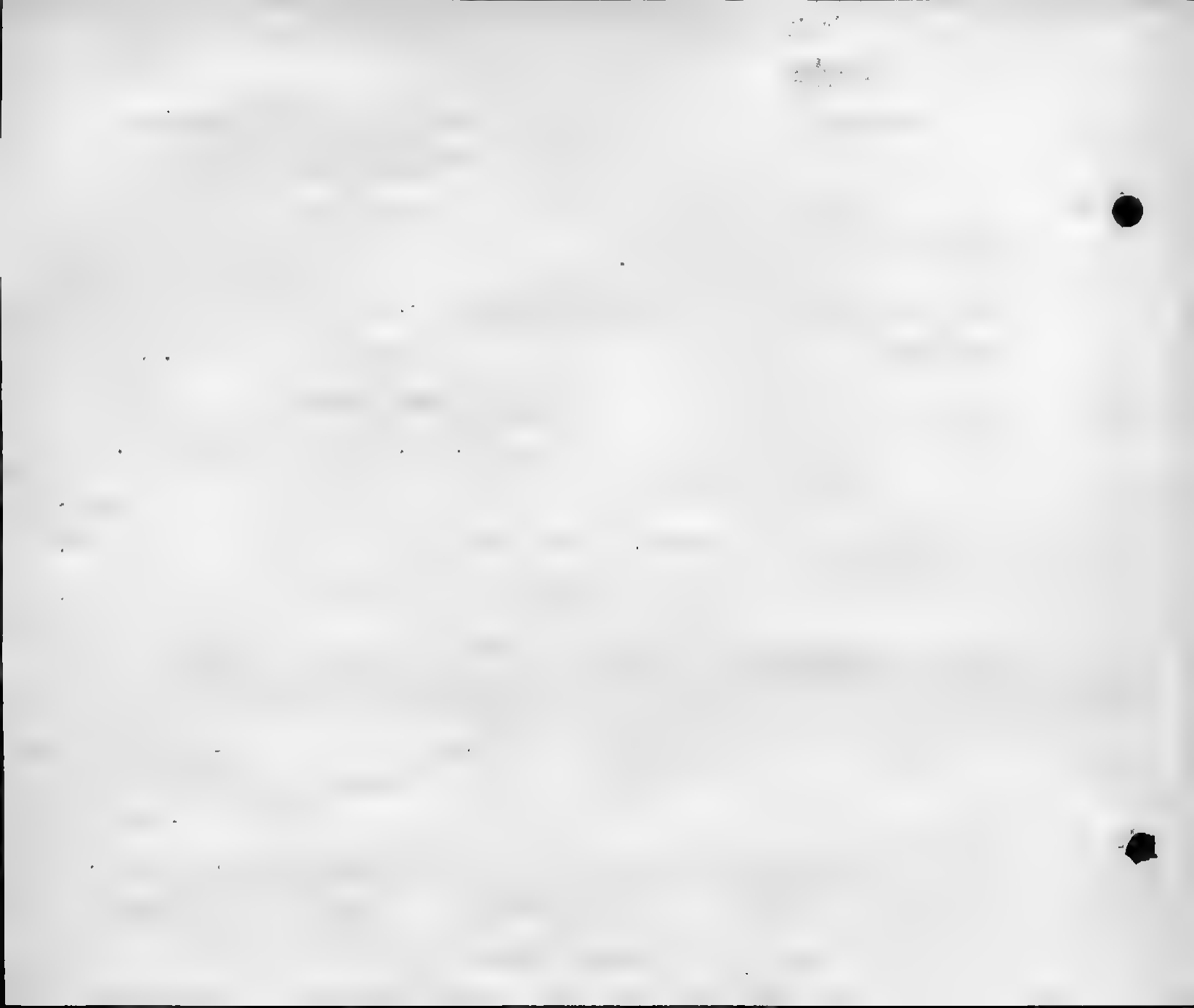
1520

01499

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b X Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shady Nook Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edna M. Belt		4. DATE OF DEATH February 20 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 3, 1884
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joshua Hilton		14. MOTHER'S MAIDEN NAME Emma Harvey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Wilbur G. Belt, 126 Newburg Ave-28- Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Nephritis 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Cerebral Hemorrhage DUE TO (c) Cardio-Vascular Renal Disease		INTERVAL BETWEEN ONSET AND DEATH 4 mos. 4 mos. 5 yrs. 2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-17 1956 to 2-20 1961 that (I) (we) last saw the deceased alive on 2-20 1961 and that death occurred 11:10pm on the causes and on the date stated above			
22a. SIGNATURE George E. Urban M.D.		22b. DATE SIGNED 2-22-61	
22c. PHYSICIAN'S NAME (Type) George E. Urban M.D.		22d. ADDRESS 805 Frederick Ave. Balto. 28,	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-23--1961	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	23d. LOCATION (City, town or county) (State) Howard County Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Webb		25. REC'D BY REGISTRAR FEB 24 '61	
ADDRESS 301 Frederick Road-28		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician and complete, signed in by the funeral director. After this certificate has been signed by the attending physician and complete, signed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60



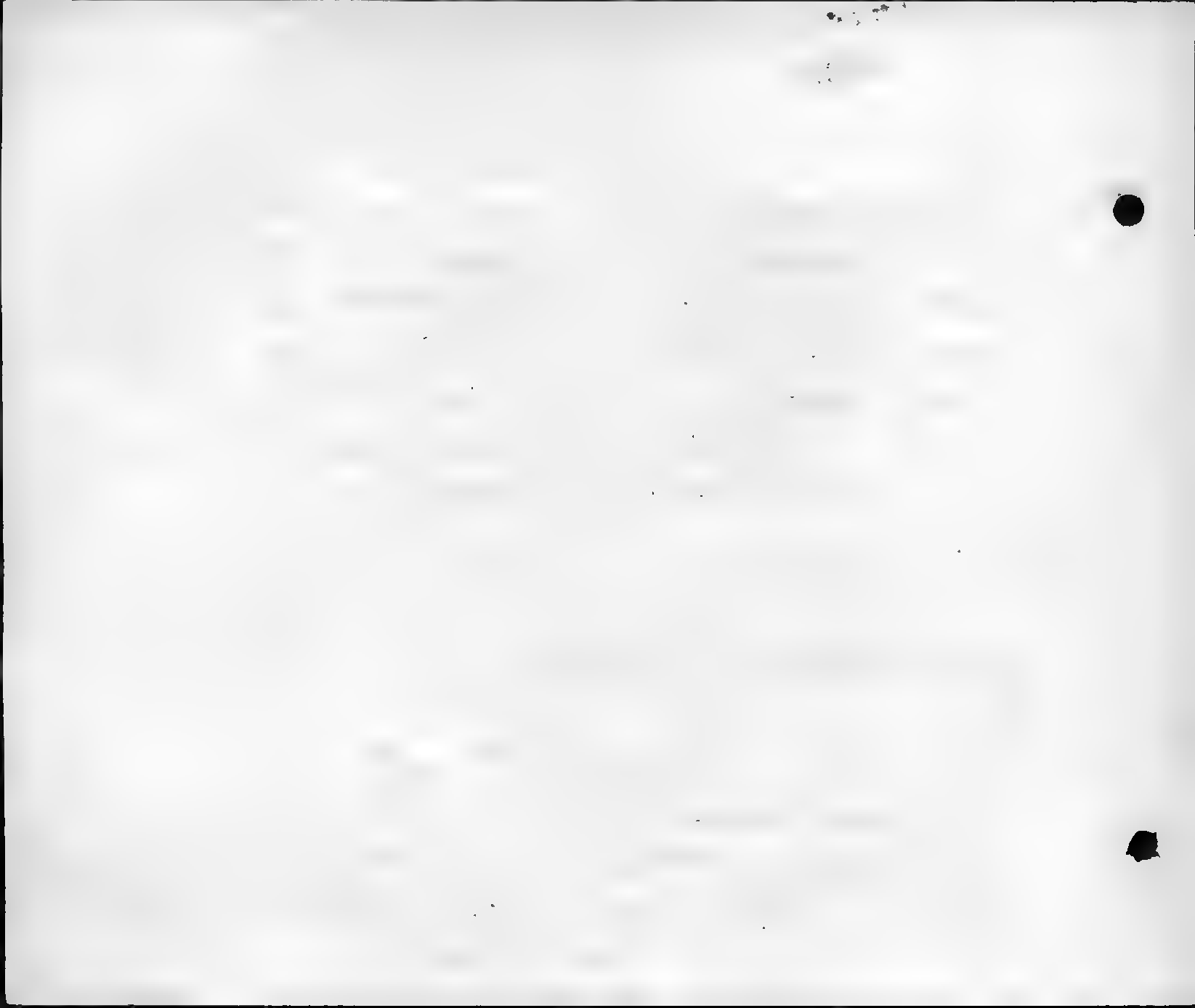
may be recorded by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1521

01500

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GARRISON MD.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE X MD.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FOXLEIGH NURSING HOME				d. STREET ADDRESS 2504 BLACK HAWK CIRCLE			
3 NAME OF DECEASED (Type or print) EMANUEL First Middle Last (MANNIE) C. BERG				4. DATE OF DEATH Month FEB. Day 24 Year 1961			
5 SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-14-1891 69 yrs	
9 AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR Months 6 Days 24 Hours 15 Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WINDOW DECORATOR		10b. KIND OF BUSINESS OR INDUSTRY Trummer		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LOUIS BERG				14. MOTHER'S MAIDEN NAME COHEN, Nora			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-07-954		17. INFORMANT L. Hillman L.P.N.		Address Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF SIGMOID WITH METASTASES DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from SEPT 1960 to FEB 24, 1961 , that (I) (we) last saw the deceased alive on 2/24 1961 , and that death occurred at 12:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE Leon E. Kassel				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) LEON E. KASSEL, M.D.	
22d. ADDRESS 3501 ST. PAUL ST., Baltimore 18, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL CREMATION, REMOVAL, (Specify)		23b. DATE THEREOF Feb 26/61		23c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship		23d. LOCATION (City, town, or county) (State) Baltimore, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Art Geunson				25a. REC'D BY REGISTRAR Art Geunson		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
25c. ADDRESS 6010 Reist Road				25d. DATE FEB 27 '61			



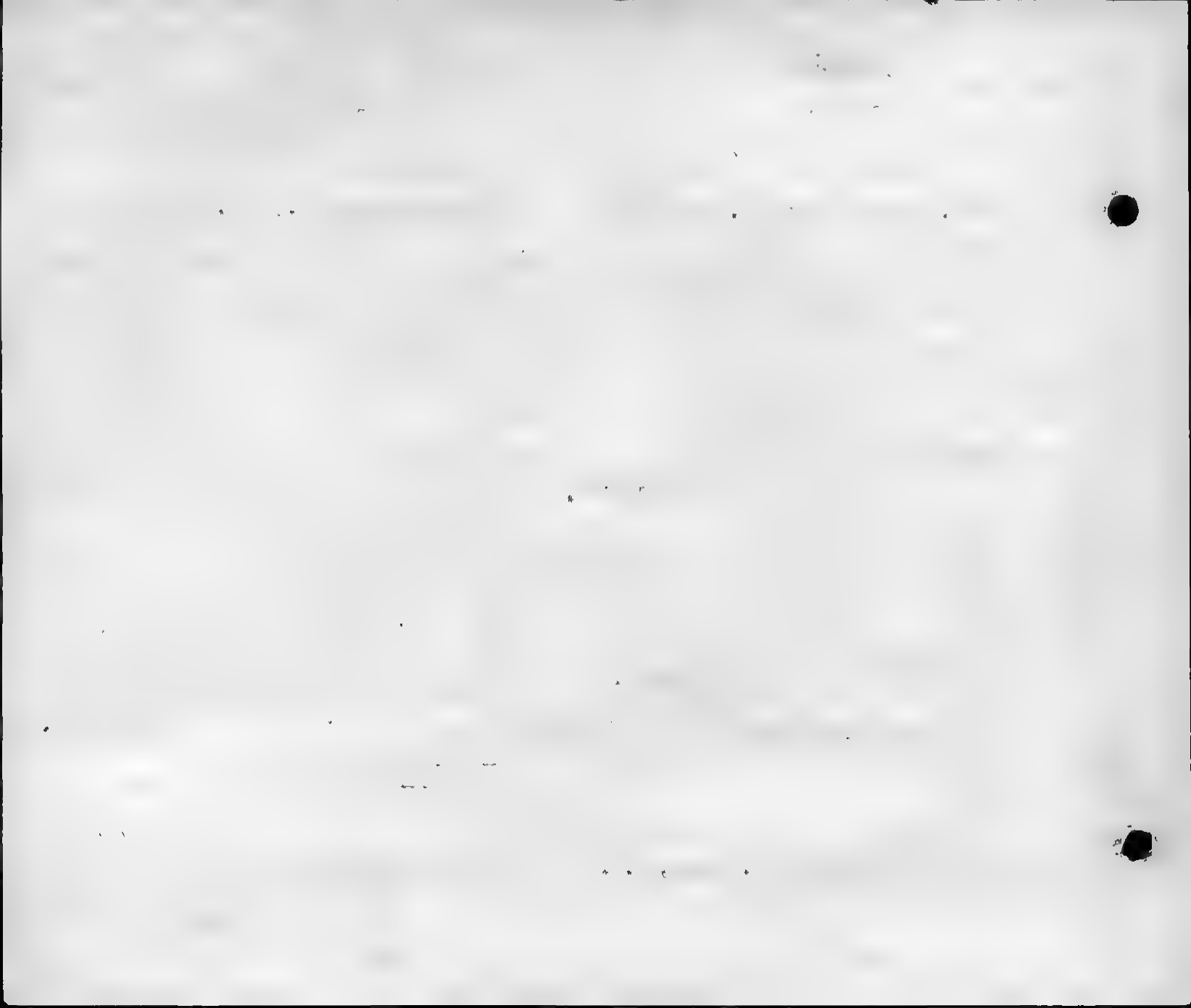
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1522 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01501											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN IL ?????				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 311 E. Pennsylvania Ave. (rear of)				d. STREET ADDRESS Dulaney Valley Apts., Apt. 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MIRIAM VERA BINDERIM				4. DATE OF DEATH Month February Day 3 Year 19 61							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2-4-1898		9. AGE (in years last birthday) 62 yrs.		IF UNDER 1 YEAR Months xx Days xx	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public Relations				10b. KIND OF BUSINESS OR INDUSTRY self-employed				11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emery A. Matthews				14. MOTHER'S MAIDEN NAME Mattie Holland				Address Hurst Texas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. ???				17. INFORMANT Geo. F. Binderim, 1104 Simpson Dr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Strangulation. DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> Strangled.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Strangled.							
20c. TIME OF INJURY Month, Day, Year 2/3 1961				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Parking lot		20f. (City or town) Towson		(County) Baltimore	
										(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/3/61											
ACTUAL SIGNATURE Charles S. Petty				EXAMINER'S NAME (Type) Charles S. Petty, M.D.				Address (Street, city, town, or county) Oklahoma City, Oklahoma			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-9-1961		22c. NAME OF CEMETERY OR CREMATORY Fairlawn Cemetery		22d. LOCATION (City, town, or country) Oklahoma City, Oklahoma			
23. FUNERAL DIRECTOR Brooks Funeral Service, Towson4, Md						ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 8 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1523

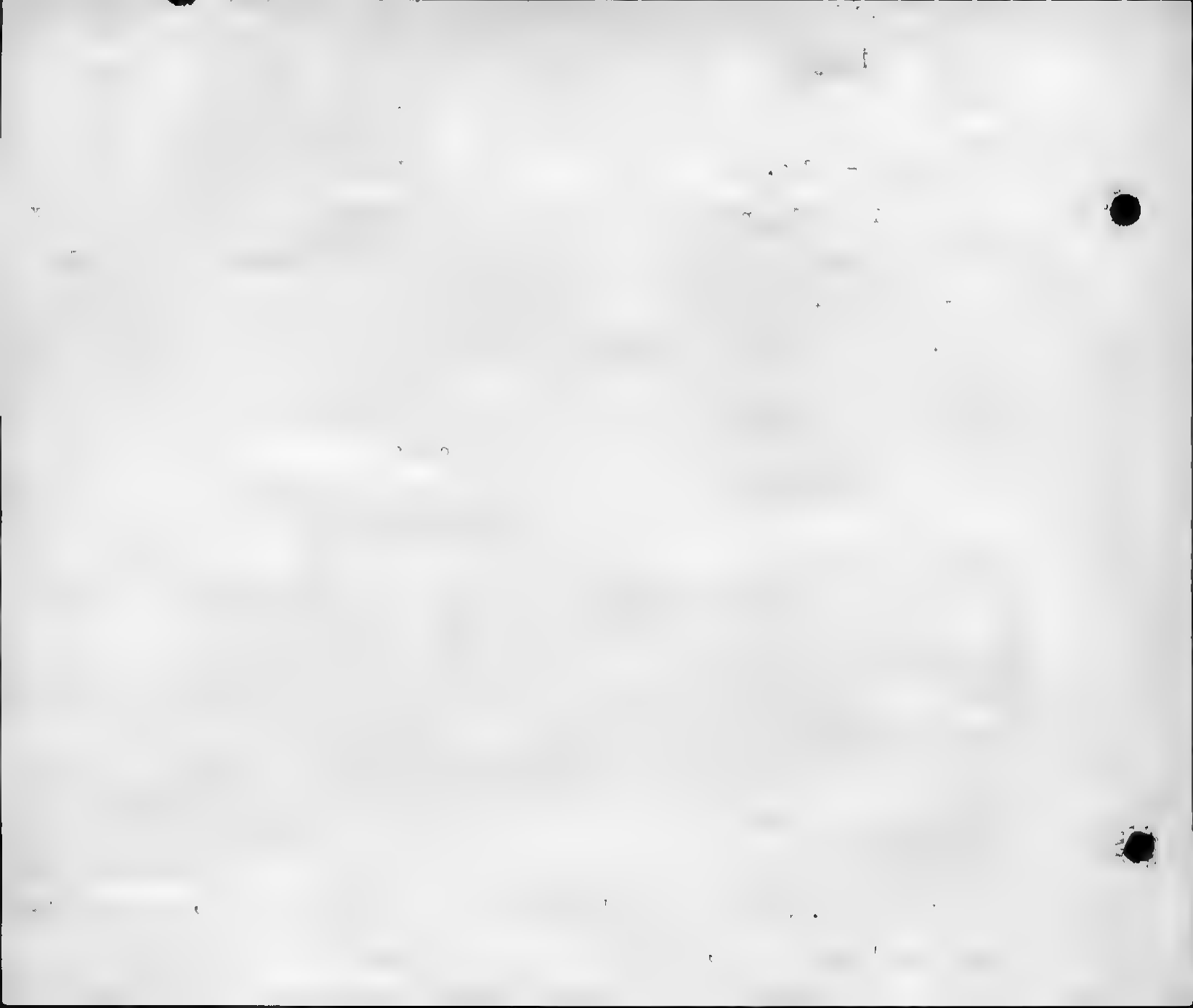
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 14 FilmG281 2-17-61 et

01502

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk - Balto. 22 c. LENGTH OF STAY IN 1b 7525 Old Battle Grove Road d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7525 Old Battle Grove Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestnut Ridge d. STREET ADDRESS Broadway Road	
3. NAME OF DECEASED (Type or print) ANNA MAY BOBLITS		4. DATE OF DEATH February 6, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 17, 1878
9. AGE (in years last birthday) 82 yrs.		10. AGE (in years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jones		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 1422.1 DUE TO Arteriosclerosis. Conditions, if any, which gave rise to immediate cause (b) Myocarditis, chronic (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan. 1950 to Feb. 5, 1961 , that (I) (we) last saw the deceased alive on Feb. 5, 1961 , and that death occurred at 7:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE David H. Andrew M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) David H. Andrew 22d. ADDRESS 33 Dundalk Ave Dundalk Md			
22b. DATE SIGNED 2/7/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 9, 1961	
23c. NAME OF CEMETERY OR CREMATORY Carroll's Cemetery		23d. LOCATION (City, town or county) (State) Greenspring Ave, Reisterstown, Md	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		25a. REC'D BY REGISTRAR FEB 14 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

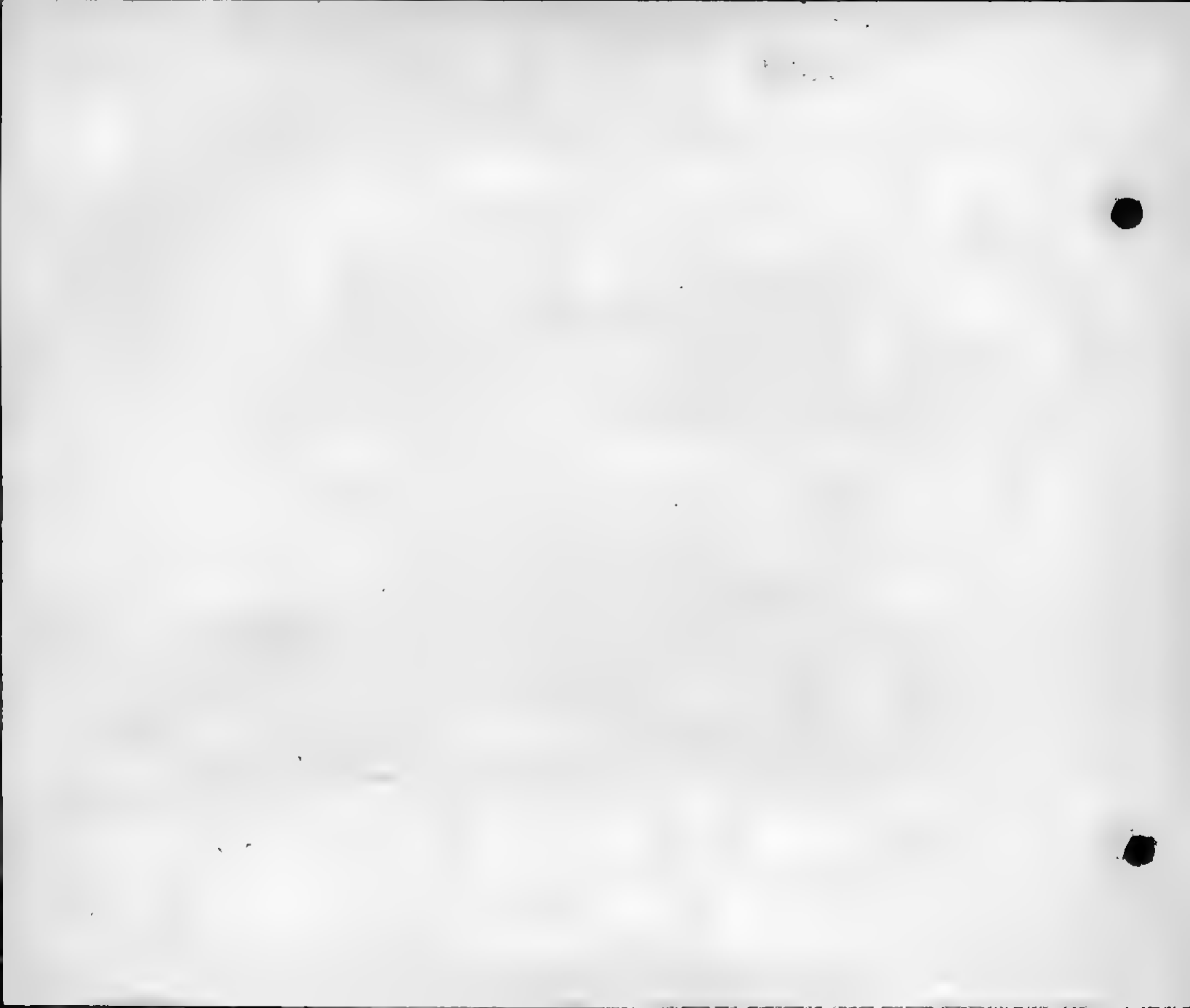
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1524

01503

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holly Hill Manor - 531 Stevenson Lane				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 19 W. 29th St d. STREET ADDRESS 19 W. 29th St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) RICHARD H. BOND		4. DATE OF DEATH FEBRUARY 3 1961		5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 2, 1894		9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 10 Min. yr.		11. IF UNDER 24 HRS. Hours 10 Min. yr.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRUKER				10b. KIND OF BUSINESS OR INDUSTRY INVESTMENT				11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME RICHARD B. BOND				14. MOTHER'S MAIDEN NAME MARIE STANG				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Mrs. Clyde Wilson - 4709 Roland Ave, Balt					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO (b) Cerebral aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerosis																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Diabetes mellitus																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.													
20c. TIME OF INJURY Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from May 25, 1951 to Feb 3, 1961 , that (I) was last saw the deceased alive on 1/31, 1961 , and that death occurred at 7:30 AM from the causes and on the date stated above.																	
22a. SIGNATURE H. R. Freeman Jr M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED Feb 3, 1961																	
22c. PHYSICIAN'S NAME (Type) H. R. FREEMAN JR 22d. ADDRESS 11 W. 29th St.																	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF FEB. 6, 1961				23c. NAME OF CEMETERY OR CREMATORY LORRAINE CEMETERY				23d. LOCATION (City, town or county) (State) BALTIMORE COUNTY, MARYLAND					
24. FUNERAL DIRECTOR'S SIGNATURE HENRY W. JENKINS & Son Co, 4905 York Road Balt 12 ADDRESS																	
25a. REC'D BY REGISTRAR Feb 7 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Hines																	

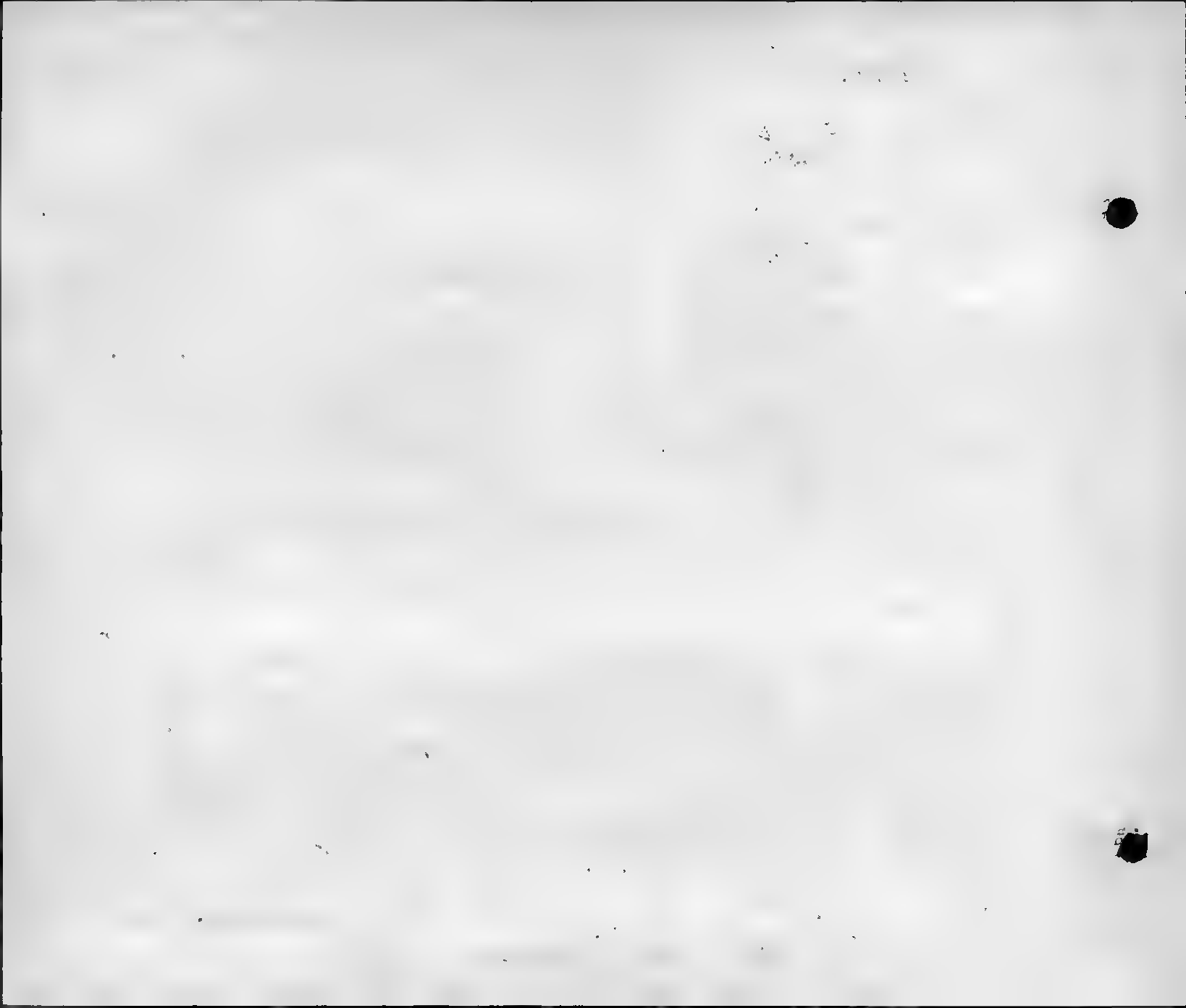
MEDICAL CERTIFICATION



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the Director, if necessary, may be retained for your files. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

18 F. M. 1-2-17 MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
1525		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
01504			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN b. <u>4yr 29days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson, Maryland</u>	
f. NAME OF DECEASED (Type or print) <u>Anna May Boring</u>		g. STREET ADDRESS <u>Murdock Road</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4, 1885</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William DeHaven</u>		14. MOTHER'S MAIDEN NAME <u>Frances Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>220-14-5590</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pyrogenic arthritis</u>			
Conditions, if any, which gave rise to immediate cause (b) <u>art. r. rheumatic cardiovascular disease</u>			
(c) <u>Fracture of left femur - accident</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>Well-Leg Traction applied 1-2-61</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Pt. was pushed down by another patient on the ward, sustaining a comminuted, intertrochanteric fracture of the left femur</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>3:30</u> P.M. <u>12-28</u> 19 <u>60</u>			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hospital</u> (County) <u>Catonsville 28, Md.</u> (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 1010 <u>Leadman</u> DATE SIGNED			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2-10-61			
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>Feb. 14, 1961</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Hampden</u>			
22d. LOCATION (City, town, or country) (State) <u>Baltimore, Md.</u>			
23. FUNERAL DIRECTOR <u>Paul E. Chmura</u> ADDRESS <u>3612 Chestnut Ave</u>			
24a. REC'D BY REGISTRAR <u>FEB 14 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>Carl G. Hume</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1526

CERTIFICATE OF DEATH

Reg. Dist. No. 01505

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe Md.</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5636 Carville Ave.</u>		d. STREET ADDRESS <u>5636 Carville Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Maryland</u> Middle <u>H.</u> Last <u>Bottiger</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>1</u> Year <u>1961</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 5th 1906</u>
9 AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> IF UNDER 24 HRS: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westinghouse</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Paul, Minn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Howe</u>		14. MOTHER'S MAIDEN NAME <u>Leonora Young</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>**</u>		16. SOCIAL SECURITY NO. <u>19-12-9479</u>	
17. INFORMANT <u>Charles Roessler</u>		Address <u>5636 Carville Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia & Congestive Failure</u> DUE TO (b) <u>Polycythemia Vera</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>2/1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2/1</u> , 19 <u>61</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. N. Frederick</u> M.D.		ADDRESS (Street, city or town, state) <u>1305 Francis Ave.</u> DATE SIGNED <u>3/3/61</u>	
PHYSICIAN'S NAME (Type) <u>J. N. Frederick M.D.</u>		<u>Baltimore, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Feb. 4-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laudon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. [Signature]</u>		ADDRESS <u>5646 Carville Ave.</u>	24a. REC'D BY REGISTRAR DATE <u>Feb 6 '61</u>
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1527
CERTIFICATE OF DEATH

01506

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Ma. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore zone 29	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradise Nursing Home, 18 Paradise Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William F. Middle Brailsford Last Sr.		4. DATE OF DEATH Month Feb. Day 9 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1878
9. AGE (In years last birthday) 82 yrs		10. UNDER 1 YEAR Months 82 Days 82 Hours 82 Min 82	11. UNDER 24 HRS Months 82 Days 82 Hours 82 Min 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY England, 56 yrs. USA	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Brailsford		14. MOTHER'S MAIDEN NAME Mary A. -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 212 09 5199	
17. INFORMANT Mrs. Frances E. Senn, 431 Rosecroft Terra		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INSUFFICIENCY 1221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE 10 yrs (c) 4 days INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN 18, 1952 to FEB 9, 1961 , that (I) (we) last saw the deceased alive on FEB 9, 1961 , and that death occurred at 4P M, from the causes and on the date stated above			
22a. SIGNATURE Norman R. Kleiman		22b. DATE SIGNED FEB 14 '61	
22c. PHYSICIAN'S NAME (Type) NORMAN R. KLEIMAN		22d. ADDRESS 3503 EDMONDSON AVE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 13/61	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City, town, or county) (State) Baltimore 7, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave		25a. REC'D BY REGISTRAR FEB 14 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

Ex

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1528

CERTIFICATE OF DEATH

01507

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SHADY NOOK CON. HOME</u>				d. STREET ADDRESS <u>104 N. STREETED ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN JACOB BREMER</u>				4. DATE OF DEATH Month Day Year <u>Feb 17 1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 1 1894</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min		11. UNDER 24 HRS. Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO. CITY</u>			
11. BIRTHPLACE (State or foreign country) <u>MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>L.C. BREMER</u> Address <u>7704 OLD HARFORD RD.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Myocarditis severe</u> (c) <u>Atherosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>year.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			
20d. INJURY OCCURRED... While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Aug 17 1901</u> to <u>Feb 17 1961</u> , that (I) <u>lost</u> saw the deceased alive on <u>Feb 17 1961</u> and that death occurred at <u>2:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wetherbee Fort</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>2-20-61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEMETERY</u>				23d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edna E. Fort</u>				25a. REC'D BY REGISTRAR <u>Feb 23 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Cristina S. Kline</u>				25c. DATE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1529

CERTIFICATE OF DEATH

01508

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2205 Boxmere Road</u>		e. STREET ADDRESS <u>2205 Boxmere Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Brandt</u> Last <u>Brittingham</u>		4. DATE OF DEATH Month <u>February</u> Day <u>14</u> , Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/19/1900</u>
9. AGE (In years) Last birthday <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Brandt</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Meyer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> <u>Mrs. Dorothy B. Cecil</u> Address <u>2205 Boxmere Road</u>	
18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>170X</u> DUE TO <u>Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } b) <u>Adenocarcinoma Rt. Breast</u> c) <u>2 yrs</u> <u>2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-16-</u> 19 <u>59</u> to <u>2-14-</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2-14-</u> 19 <u>61</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert H. Silver</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>R.H. Silver</u>		22d. ADDRESS <u>3105 N. Charles St. 18. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-17-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u>		25a. REC'D BY REGISTRAR <u>4905 York Road</u> <u>Balto. 12, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>		DATE <u>FEB 16 '61</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any-
one is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the f-
4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

1
1530
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1000 ...</u>		d. STREET ADDRESS <u>1000 ...</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas J. Buell</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Aug 12 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chauffeur/Class Co.</u>	9. AGE (In years) IF UNDER 1 YEAR, IF UNDER 24 HRS. last birthday, Months Days Hours Min. <u>77</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Buell</u>		14. MOTHER'S MAIDEN NAME <u>Christ ...</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>...</u>	
17. INFORMANT <u>Mabel Cary</u>		Address <u>310 A ...</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>...</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>...</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>...</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>...</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>...</u>	20f. (City or town) (County) (State) <u>...</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <u>...</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Feb. 21, 1961</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 1010 Leeds Ave. Balto. 20 Address (Street, city, town, or county) ACTUAL SIGNATURE <u>...</u> NAME (Type) <u>...</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 25, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Family Lot</u>		22d. LOCATION (City, town, or county) (State) <u>Gloucester Co., Virginia</u>	
23. FUNERAL DIRECTOR <u>Holland Funeral Home-1631 Druid Hill Ave</u>		24a. REC'D BY REGISTRAR <u>FEB 27 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>...</u>			



1531

CERTIFICATE OF DEATH

01510

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DURDALK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DURDALK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>3470 LOGAN VIEW DRIVE</u>		d. STREET ADDRESS <u>13470 LOGAN VIEW DRIVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND ELLYD BURMAN</u>		4. DATE OF DEATH Month Day Year <u>FEB 9 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JULY 16-1895</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>MEADE BURMAN</u>	
14. MOTHER'S MAIDEN NAME <u>TERESA MEADE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES IWW #</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>ROBT. BURMAN 3472 LOGAN VIEW DR.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>4 Months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar. 10, 1952</u> to <u>9 Feb. 1961</u> , that I last saw the deceased alive on <u>Feb. 8, 1961</u> , and that death occurred at <u>4:30 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>W. H. Morrisson</u> M.D.		PHYSICIAN'S NAME (Type) <u>W. H. Morrisson MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/13/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAMS FUNERAL HOME - DUNDALK</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 14 1961</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

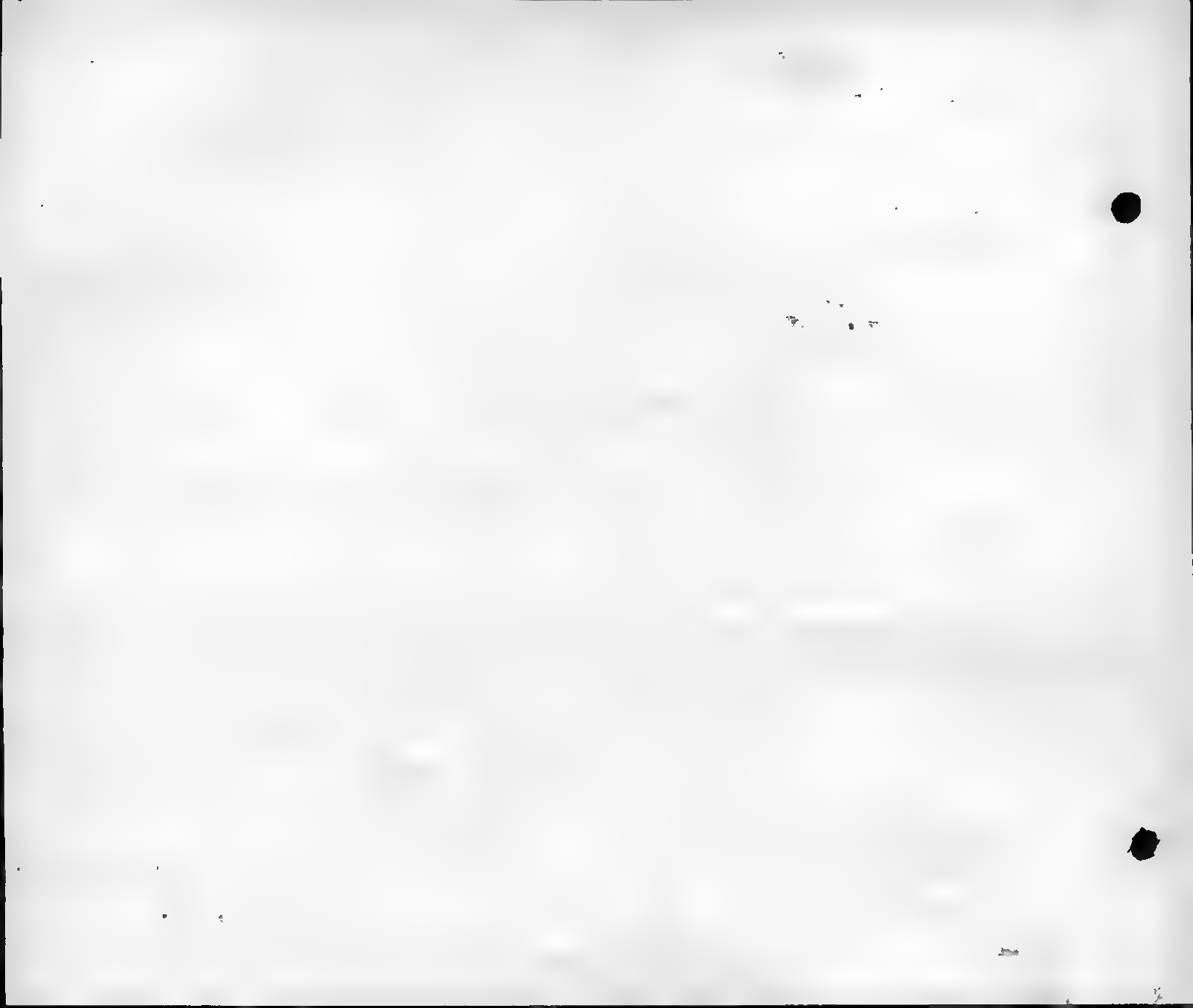
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



VR ATIS (4)
15M 9/59

01511

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution (Residence before admission) V STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 15 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 29	
f. STREET ADDRESS 761 Grantley Str		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR FRED CALTRIDER First Middle Last		4. DATE OF DEATH Month 2 Day 21 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5.5.1878
9. AGE (In years last birthday) 82 yrs.		10. UNDER 1 YEAR Months 8 Days 21 Hours 0 Min 0	11. UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar tender		10b. KIND OF BUSINESS OR INDUSTRY McWashing, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DANIEL CALTRIDER		14. MOTHER'S MAIDEN NAME PRICILLA BAILEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Records, Mt. Wilson State Hospital	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis DUE TO 8 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) INTERVAL BETWEEN ONSET AND DEATH (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease. Diabetes mellitus 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour, p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11. 9 , 19 59 , to 2. 21 , 19 61 , that (I) (we) last saw the deceased alive on 2. 21 , 19 61 , and that death occurred at 12:47 from the causes and on the date stated above			
22a. SIGNATURE W. Newcomer M.D.		22b. DATE SIGNED 2.21.1961	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/25/61	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge		23d. LOCATION (City, town or county) (State) Wash Blvd, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Quentin E. Donovan - 3818 Roland Ave		25a. REC'D BY REGISTRAR DATE FEB 24 '61	
25b. REGISTRAR'S SIGNATURE Carlton E. Evans			



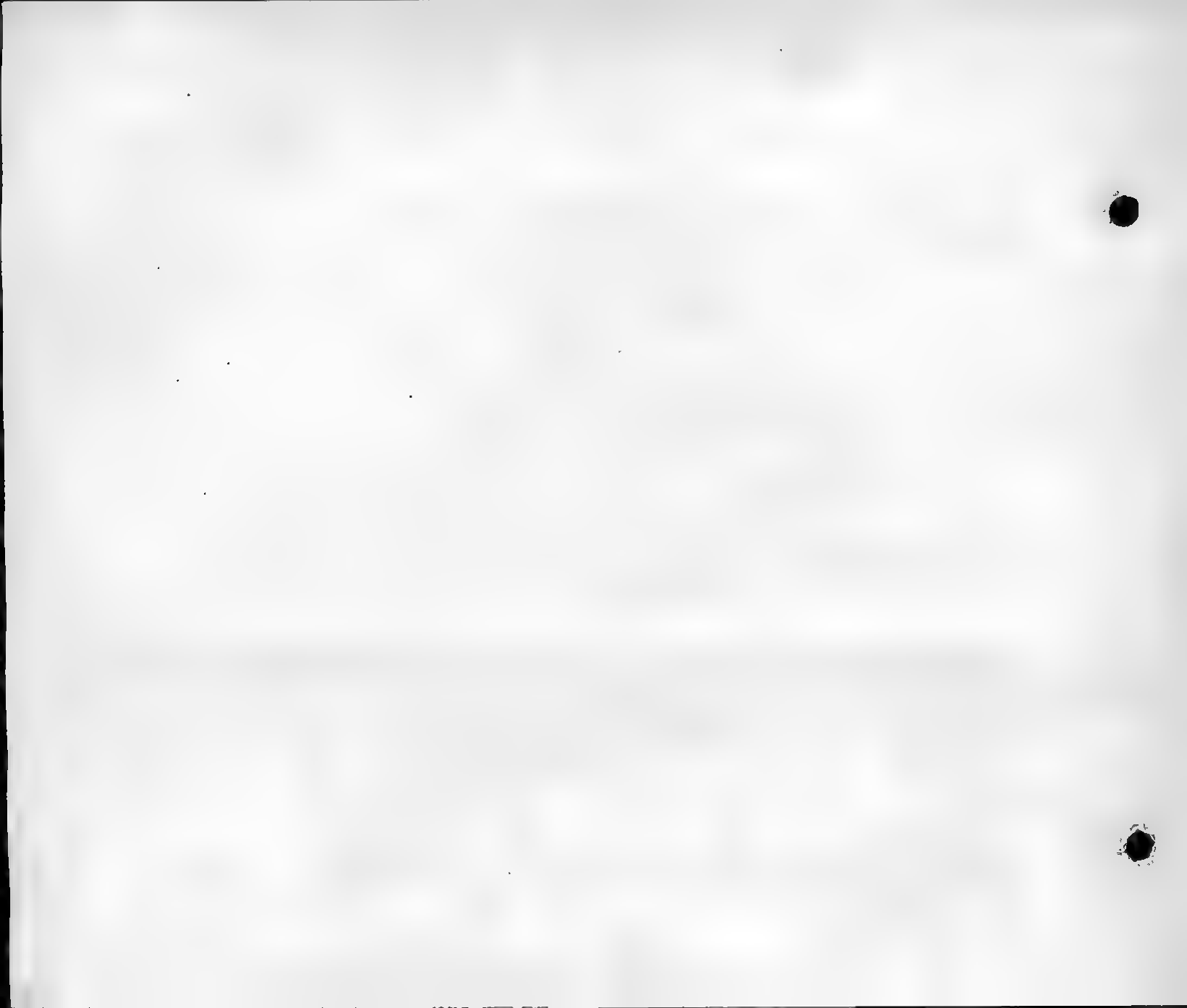
1533 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01512

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> b. CITY OR TOWN <u>Balto</u> and give nearest street		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>	
3. NAME OF DECEASED (Type or print) <u>Eugene Bernard Campbell</u> First Middle Last		4. DATE OF DEATH <u>Feb 12 1961</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11 1907</u> Month Day Year
9. AGE (In years last birthday) <u>46</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Used Car Sales</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Caroline McMullen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>16-01-135</u>	
17. INFORMANT <u>Mary Campbell</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis. Sudden</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic C.V.D. 24 yrs?</u> (c) <u>He</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Heavy Alcohol Consumption</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank T. Kasik Jr.</u> EXAMINER'S NAME (Type) <u>FRANK T KASIK JR.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 14 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Burien Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Hester</u> ADDRESS <u>1111 Chatterbox Rd, Baltimore</u>		24a. REC'D BY REGISTRAR <u>Charles L. Hester</u> DATE <u>FEB 14 '61</u>	
24b. REGISTRAR'S SIGNATURE			

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

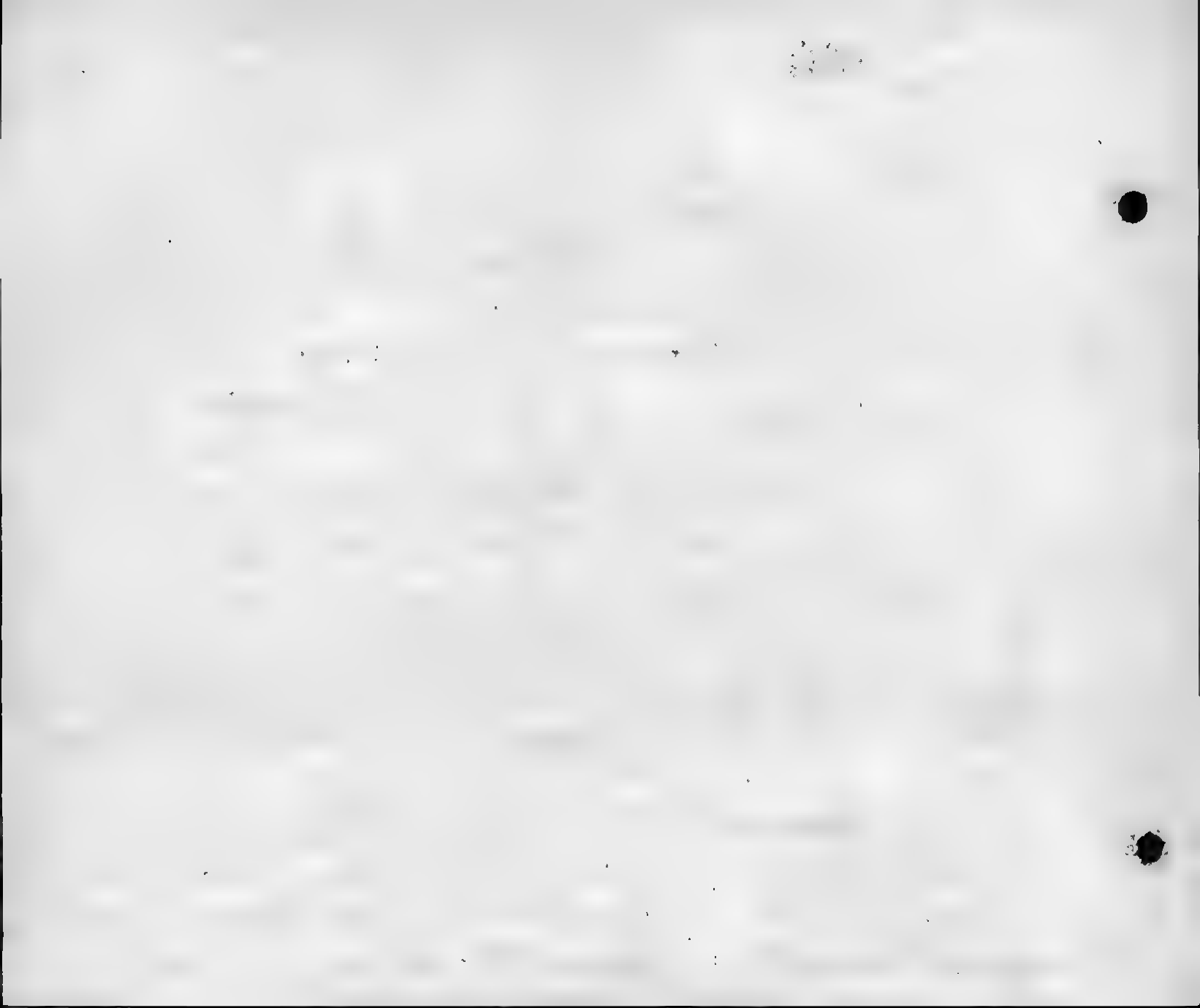
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1534

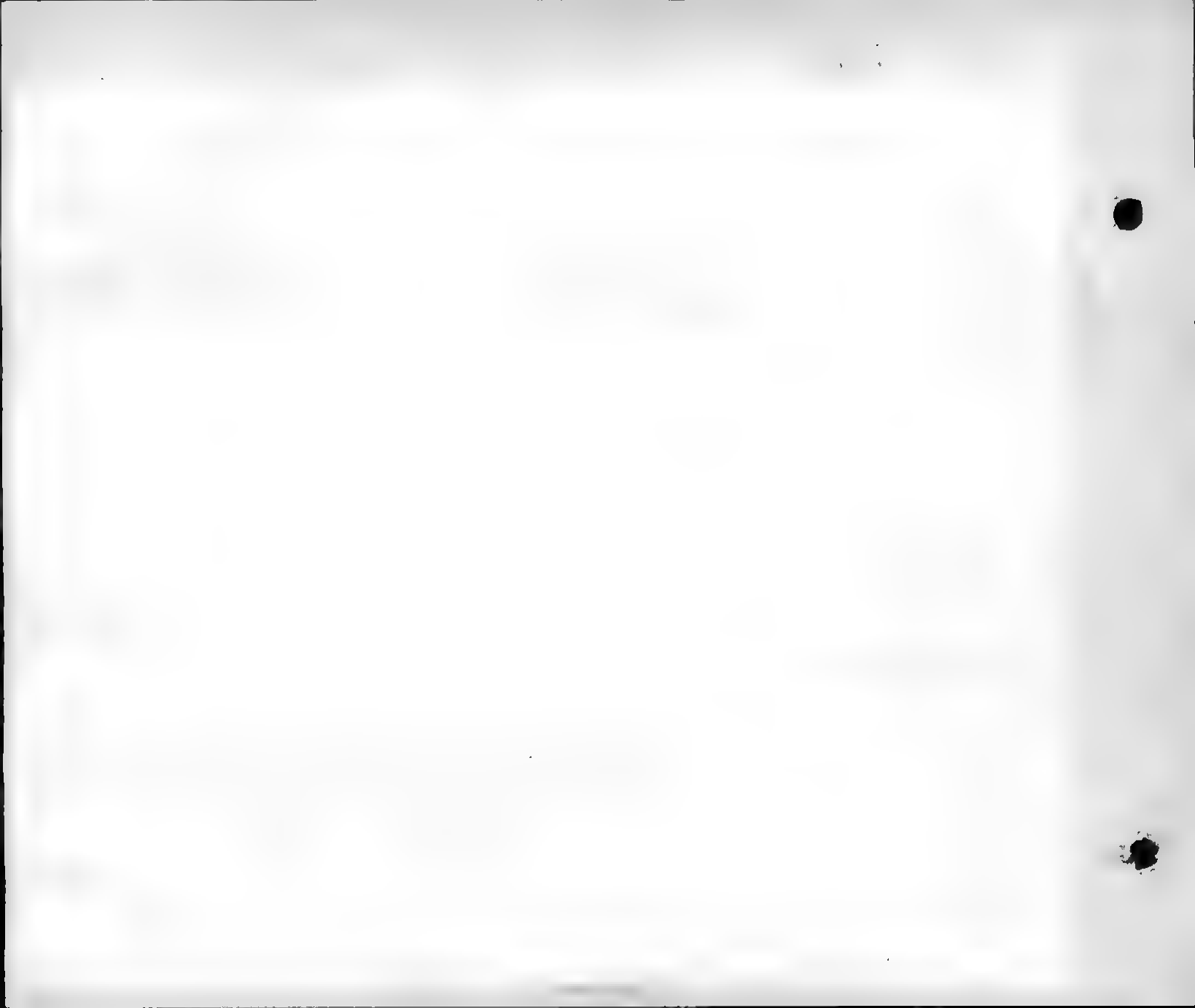
CERTIFICATE OF DEATH

01513

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 4mth6dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE Where deceased lived, if last full one; Residence before admission a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1215 Washington Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Connolly Campbell		4. DATE OF DEATH February 23 1961	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 12, 1880	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 19 Days 13 Hours 15 Min. 00	
11. BIRTHPLACE (County & State, or foreign country) Maryland Baltimore		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas J. Connolly		14. MOTHER'S MAIDEN NAME Pauline 97 Meyers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 218-05-2117	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis, severe DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 4 1961 to Feb. 23 1961 , that (I) (we) last saw the deceased alive on Feb. 23 1961 , and that death occurred at 7:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 2-23-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2.25/61	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION (City, town or county) (State) Woodlawn Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Cowan		25a. REC'D BY REGISTRAR 29 Collins St.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		DATE FEB 24 '61	



VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01515

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN <u>40 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3202 Sequoia Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM A. CHATMON, SR.</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>10/14/96</u> 9. AGE (In years last birthday) <u>64</u> yrs. 10. UNDER 1 YEAR <input type="checkbox"/> 11. UNDER 24 HRS. <input type="checkbox"/> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		4. DATE OF DEATH <u>FEBRUARY 5 19 61</u> 13. FATHER'S NAME <u>Thomas Chatmon</u> 14. MOTHER'S MAIDEN NAME <u>Hester Tyler</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>Yes</u> 16. SOCIAL SECURITY NO. <u>WW I</u> 17. INFORMANT <u>Clin. Rec. VAH, Balto. Md. Fort Howard Division</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF STOMACH WITH ABDOMINAL CARCINOMATOSIS</u> DUE TO (b) <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>UNKNOWN</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>151X</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>VAH, Balto. Md. Fort Howard Division</u> 20f. (City or town) <u>Baltimore</u> (County) <u>Maryland</u> (State) <u>Maryland</u> 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Dec. 27 1960</u> to <u>Feb. 5 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Feb. 5 1961</u> , and that death occurred at <u>3:20AM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Arthur T. Faulk</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>2/5/61</u> 22c. PHYSICIAN'S NAME (Type) <u>ARTHUR T. FAULK, M.D.</u> ADDRESS <u>1639 N. Broadway Baltimore, Maryland</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Feb. 9, '61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> 23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u> (State) <u>Maryland</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Lewis</u> ADDRESS <u>1639 N. Broadway Baltimore, Maryland</u> 25a. REC'D BY REGISTRAR <u>FEB 14 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Haines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs in a hospital, the certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A (4)
15M 9/60

1941



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

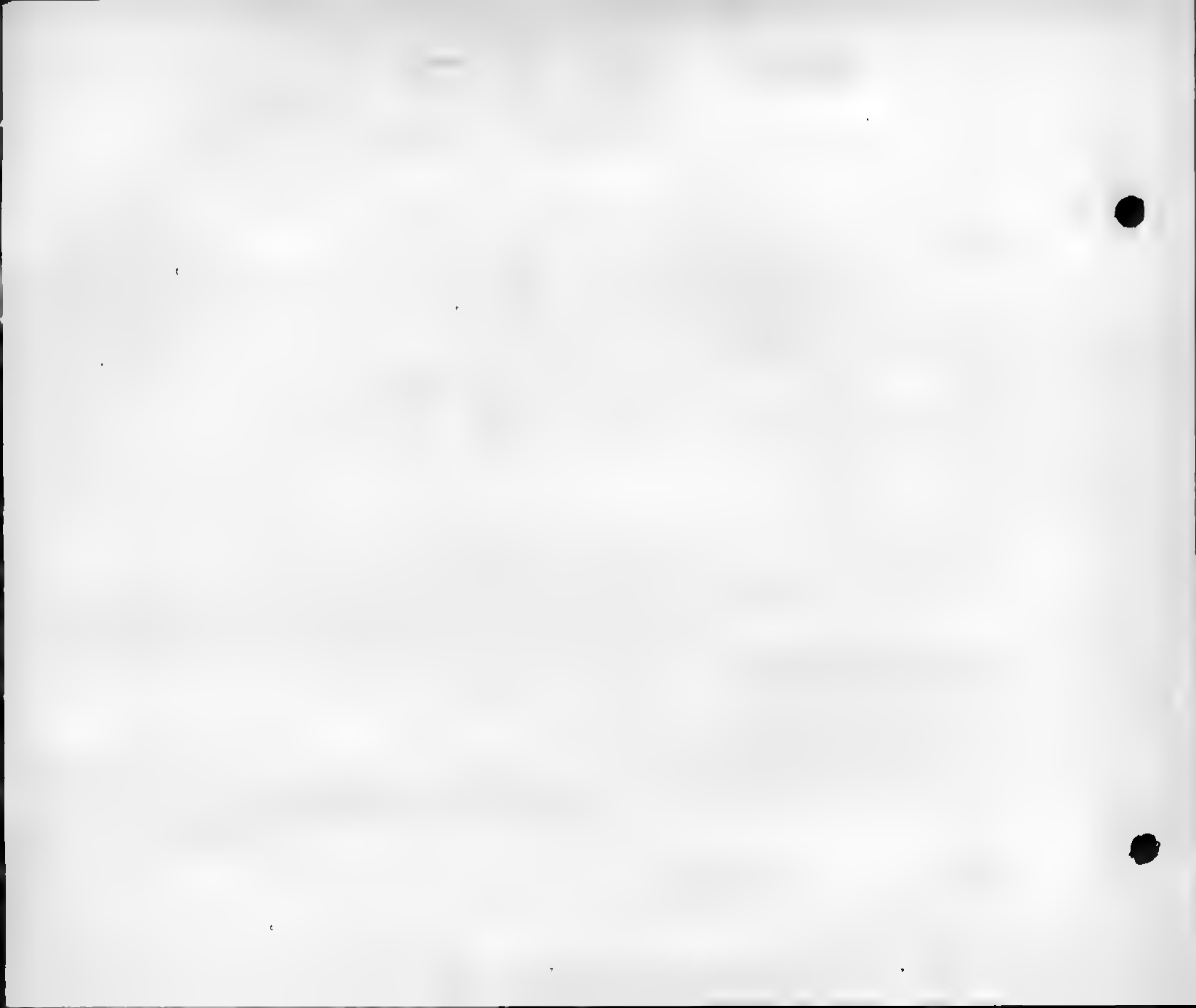
Reg. Dist. No.

01516

1537

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex (21)</u>		c. LENGTH OF STAY IN 1b <u>Essex (21)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>300 Holly Neck Road</u>		d. STREET ADDRESS <u>300 Holly Neck Road</u>	
3. NAME OF DECEASED (Type or print) <u>AGOSTINO CILENZA</u>		4. DATE OF DEATH Month <u>February</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 1, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	9. AGE (in years last birthday) <u>86</u> yrs IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u> ✓	
13. FATHER'S NAME <u>Ralph Cilenza</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>217-07-3135</u>	
17. INFORMANT <u>Maria Luciano Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>Arteriosclerosis heart dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis heart dis</u> DUE TO (c) <u>Arteriosclerosis heart dis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Possible metastatic carcinoma</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1961</u> Hour <u>4:11</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/11</u> , 19 <u>55</u> , to <u>2/16</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/11</u> , 19 <u>61</u> , and that death occurred at <u>4:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>434 Eastern Ave. Essex, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. BLA-T M D</u>		DATE SIGNED <u>Essex, Md. 2/16/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/18/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		24a. REC'D BY REGISTRAR <u>James E. Priddy</u>	
24b. REGISTRAR'S SIGNATURE <u>James E. Priddy</u>		24c. ADDRESS <u>1407 Eastern Ave.</u>	
24d. DATE <u>FEB 17 '61</u>		24e. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1538 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01511

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7920 Beverly Road</u>		e. STREET ADDRESS <u>7920 Beverly Road</u>	
3. NAME OF DECEASED (Type or print) <u>Dante</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-13-1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel mill Emp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	9. AGE (In years last birthday) <u>48</u> yrs.
13. FATHER'S NAME <u>Vito Cilumbrello</u>		14. MOTHER'S MAIDEN NAME <u>Dannaiella Calasanti</u>	
15. WAS DECEASED DYER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> DUE TO (b) <u>sarcoidosis severe, generalized Pulmonary</u> DUE TO (c) <u>same</u>		INTERVAL BETWEEN ONSET AND DEATH <u>several minutes approx. 1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John C. Hyle</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John C. Hyle</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2-4-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>5305 Harford Road</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

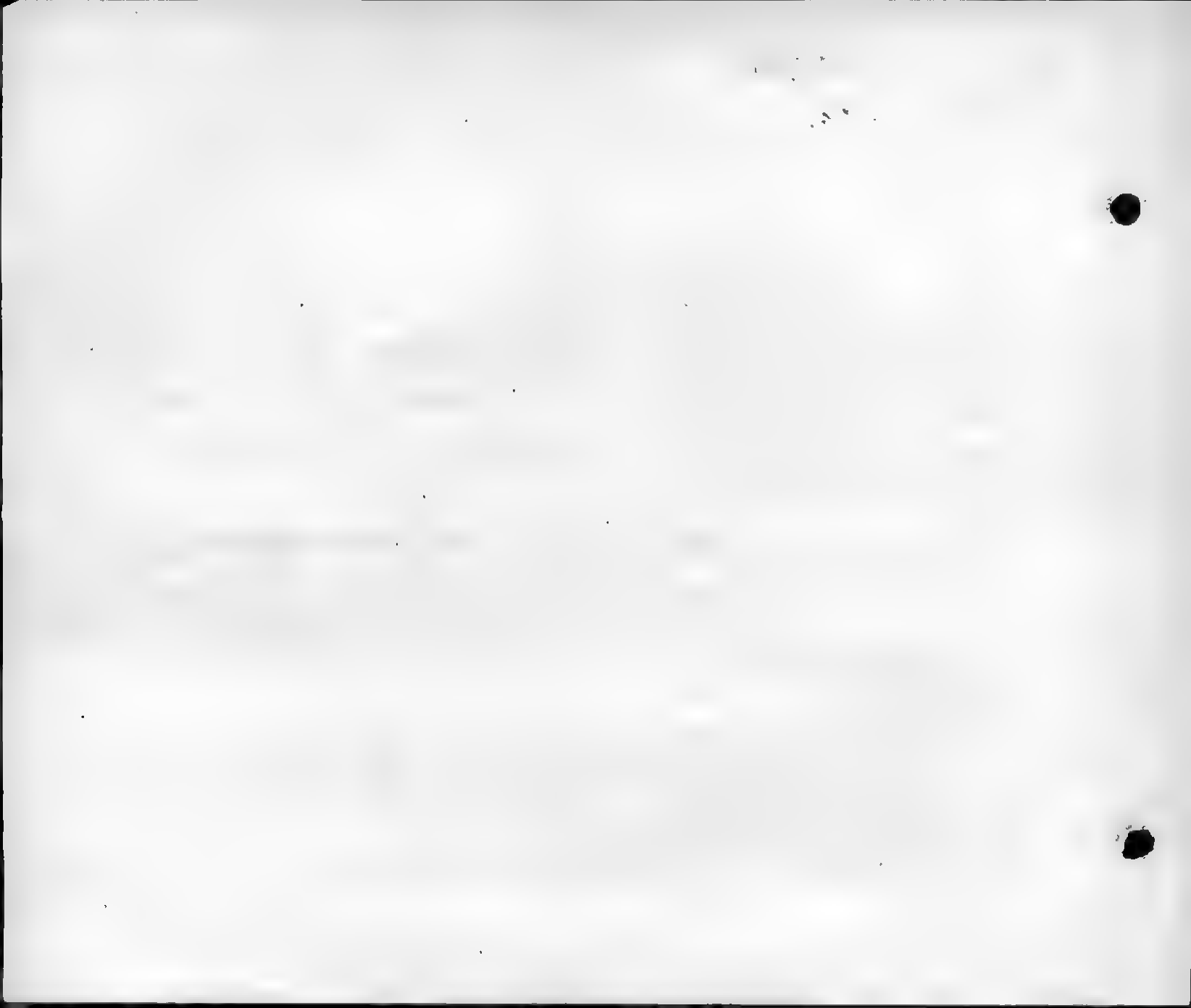
DATE FEB 6 '61



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1539 CERTIFICATE OF DEATH 01518

1 PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harriborough</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Harriborough</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARRIE - E - CLARK</u>				4. DATE OF DEATH Month Day Year <u>Feb 1 1961</u>			
5 SEX <u>TH</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-17-1879</u>		9 AGE (In years last birthday) <u>82</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Miller</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Bennett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO. <u>711</u>		17 INFORMANT Address <u>Geo Miller - Upper - Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Cerebrovascular Disease</u> DUE TO (c) <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 10 1960</u> to <u>Jan 28 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 28 1961</u> , and that death occurred at <u>21 M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Bush</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		22d. ADDRESS <u>Wampstead Maryland</u>					
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-4-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		23d. LOCATION (City, town, or county) (State) <u>Greenwood Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin & Hyman Harnopald Md</u>				25a. REC'D BY REG STRAR DATE <u>FEB 8 '61</u>		25b. REGISTRAR'S SIGNATURE <u>C. M. 2, 1961</u>	



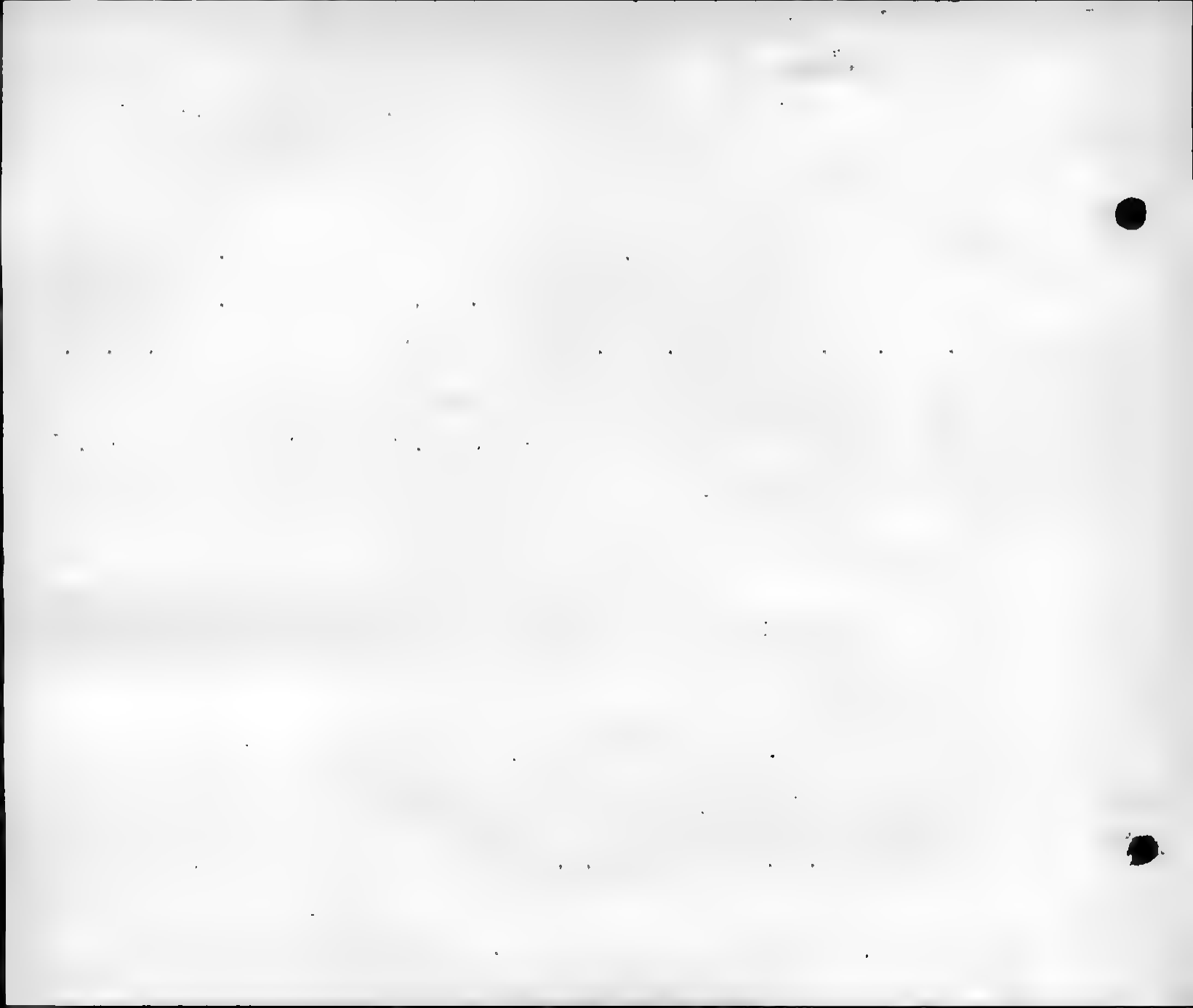
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

015119

1540

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE Md. b COUNTY Baltimore			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1725 Wilson Avenue #27				d STREET ADDRESS 1 1725 XXXX Wilson Avenue			
3 NAME OF DECEASED (Type or print) First Ruby Middle W. Last Coleman				4. DATE OF DEATH Month Feb. Day 11 , Year 1961			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1886		9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) ret. Eng.		10b. KIND OF BUSINESS OR INDUSTRY Fed. Gov. t		11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Coleman				14. MOTHER'S MAIDEN NAME Esther Myers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO		17. INFORMANT Marianne A. Maddox 1725 Wilson Ave. #27			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis, recurrent Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 3, 1960 to Feb 11, 1961 , that (I) (we) last saw the deceased alive on Jan 25, 1961 , and that death occurred at 5 PM , from the causes and on the date stated above							
22a. SIGNATURE C. A. Rossberg, M.D.				22b. PHYSICIAN'S NAME (Type) C. A. Rossberg, M.D.		22c. ADDRESS 2436 Washington Blvd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/16/61		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION (City, town, or county) (State) Springfield, Nebraska	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Ave.				25a. REC'D BY REGISTRAR DATE FEB 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

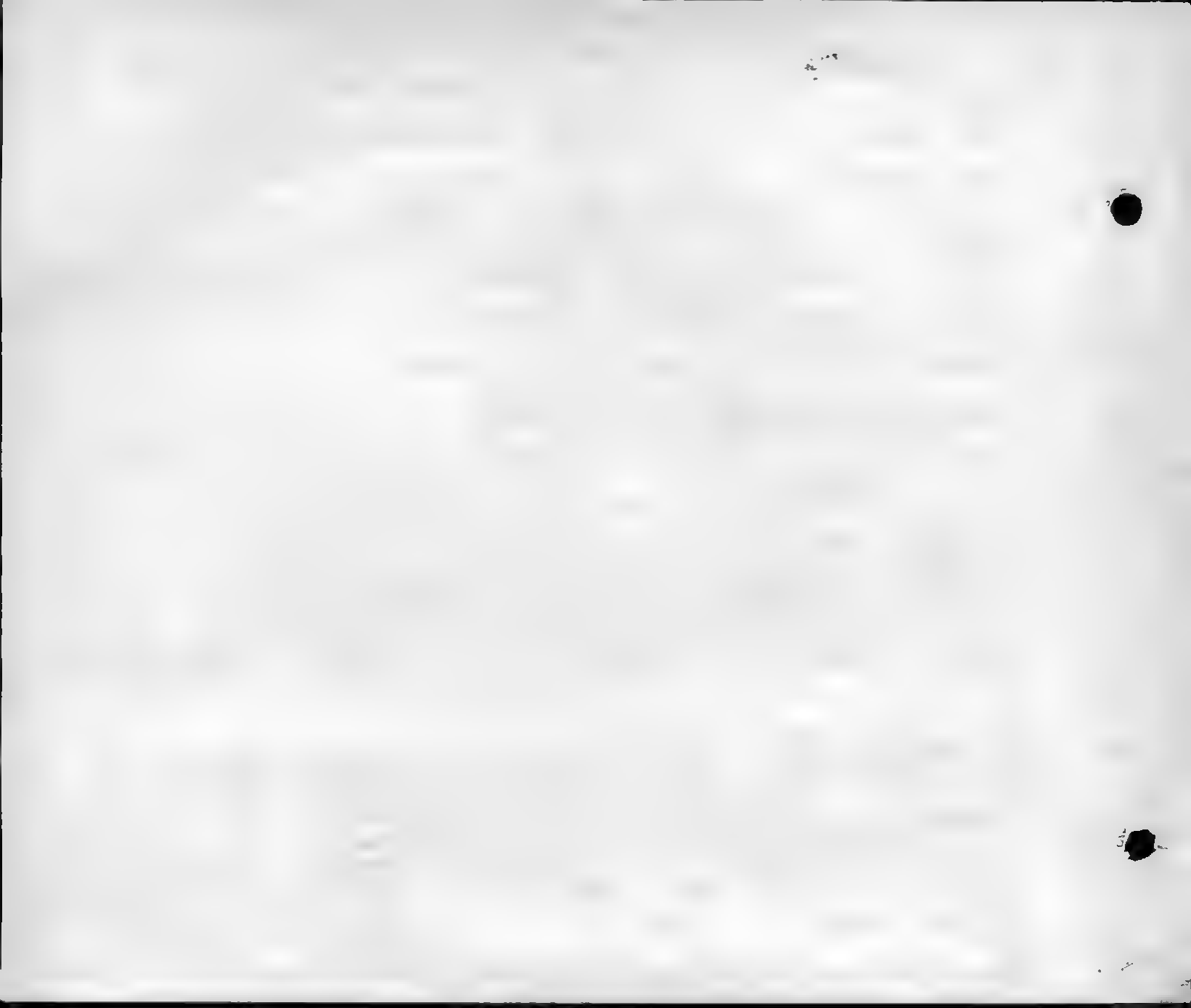
1541 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01520

Items 8 & 9, telephone call - Wilson Funeral Home Reg. Dist. No. 12/21/61-61-61

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>County School</u>				d. STREET ADDRESS <u>836 Whitmore Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Coleman</u> Last <u>Jr</u>				4. DATE OF DEATH Month <u>2</u> - Day <u>16</u> - Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29, 1912</u>		9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Columbia S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Coleman Jr</u>				14. MOTHER'S MAIDEN NAME <u>Callie Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WWI</u>		17. INFORMANT Address <u>Corrine Coleman - Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C Collins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JACK C Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Erroy C. Wilson</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any del- necessary, please ex-
cure the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral or. Page 4 should be
forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation,
or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

1542

1542

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01521

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6915 Dunmanway		d. STREET ADDRESS 6915 Dunmanway	
3 NAME OF DECEASED (Type or print) First Middle Last Charles T Conrad		4. DATE OF DEATH Feb 4 1961 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 6 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist ret		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 72 yrs
11. BIRTHPLACE (State or foreign country) Wash D C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Chrals T Conrad (Charles)		14. MOTHER'S MAIDEN NAME Mary Lyons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO W W L	
17. INFORMANT Mrs Blanche Conrad 6915 Dunmanway		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Arteriosclerosis - Coronary Condit ons. if any, which gave rise to immediate cause (a) stating the under-lying cause last DUE TO Arteriosclerosis (b) Arteriosclerosis (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 12 hr 2 yrs 3 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from July 1958 to Feb 1961 , that (I) (we) last saw the deceased alive on Feb 4 1961 , and that death occurred at 4 PM , from the causes and on the date stated above			
22a. SIGNATURE James T. Means		22b. DATE SIGNED 2-2-61	
22c. PHYSICIAN'S NAME (Type) James T. Means		22d. ADDRESS 500 H. St. Balt 19 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF Feb 8/61	
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat Cemetery		23d. LOCATION (City, town, or county) (State) Arlington Va	
24. FUNERAL DIRECTOR'S SIGNATURE Ulrich Funeral Home 2112 Dundalk Ave		25a. REC'D BY REGISTRAR FEB 9 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Means	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1543 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

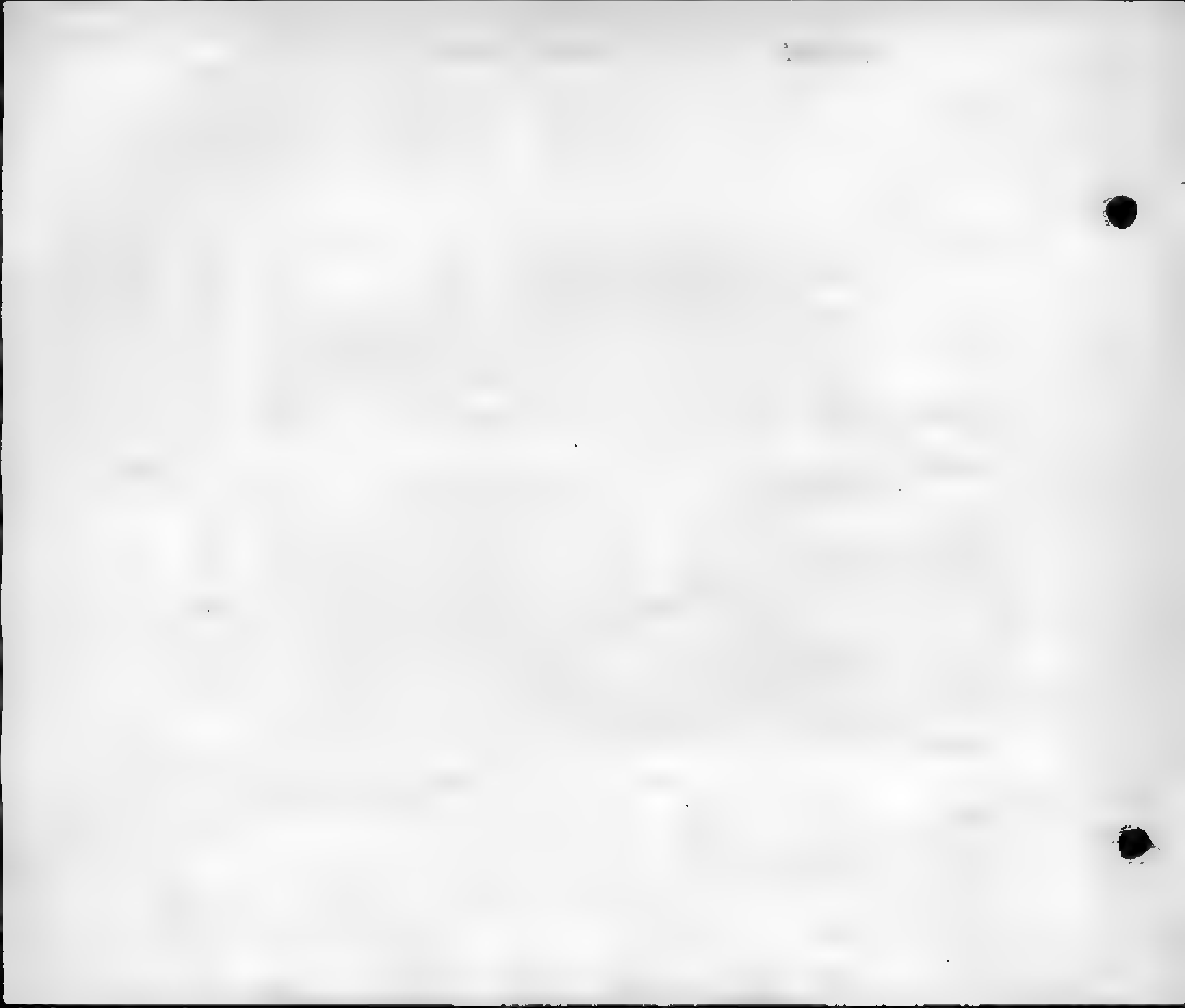
01522

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>2nd</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Edmondson & Hutton Ave</u> e. STREET ADDRESS <u>616 Woodhurst Way</u> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. DATE OF DEATH <u>Feb. 11</u> 1961 e. MONTH <u>Feb.</u> DAY <u>11</u> YEAR <u>1961</u>	
3. NAME OF DECEASED (Type or print) <u>EDWIN R. CONRAD</u> First Middle Last 4. SEX <u>Male</u> 5. COLOR OR RACE <u>White</u> 6. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 7. DATE OF BIRTH <u>1/4/07</u> 8. AGE (In years, months, days) <u>54</u> yrs. 9. IF UNDER 1 YEAR Months Days 10. IF UNDER 24 HRS. Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookbinder, Pugich's Inc.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u> 11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Otto Conrad</u> 14. MOTHER'S MAIDEN NAME <u>Phototechniques</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>216-07-4954</u> 17. INFORMANT <u>Matilda Conrad</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>W. E. Mc Groth</u> EXAMINER'S NAME (Type) <u>W. E. Mc Groth</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2/13/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> 22b. DATE THEREOF <u>2/15/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Towson Park</u> 22d. LOCATION (City, town, or county) (State) <u>Baltimore md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Mc Groth & Son Co. 28</u> 24a. REC'D BY REGISTRAR <u>Feb 15 '61</u> 24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1544

CERTIFICATE OF DEATH

01523

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>House of Pines</u>		d. STREET ADDRESS <u>16 Huntington Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Isabel</u> First <u>Conway</u> Middle <u>Conway</u> Last		4. DATE OF DEATH <u>2</u> Month <u>16</u> Day <u>1961</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 5, 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>	
13. FATHER'S NAME <u>Thomas Burke</u>		14. MOTHER'S MAIDEN NAME <u>Mary Moon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>John J. Martin, Long Point Resident</u>		Address <u>9446</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: <u>Myocardial infarction</u> DUE TO <u>Chronic coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Chronic coronary artery disease</u> DUE TO <u>Chronic coronary artery disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 1/2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-3-1958</u> , to <u>2-16-1961</u> , that I last saw the deceased alive on <u>2-13-1961</u> , and that death occurred at <u>2:10 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William K. Gallager</u>		ADDRESS (Street, city or town, state) <u>6207 Frederick Ave. Baltimore 28, Md.</u>	
PHYSICIAN'S NAME (Type) <u>William K. Gallager</u>		DATE SIGNED <u>2-16-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 24, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Lewis</u>		ADDRESS <u>1400 S. Rhodes St</u>	
24a. REC'D BY REGISTRAR <u>FEB 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

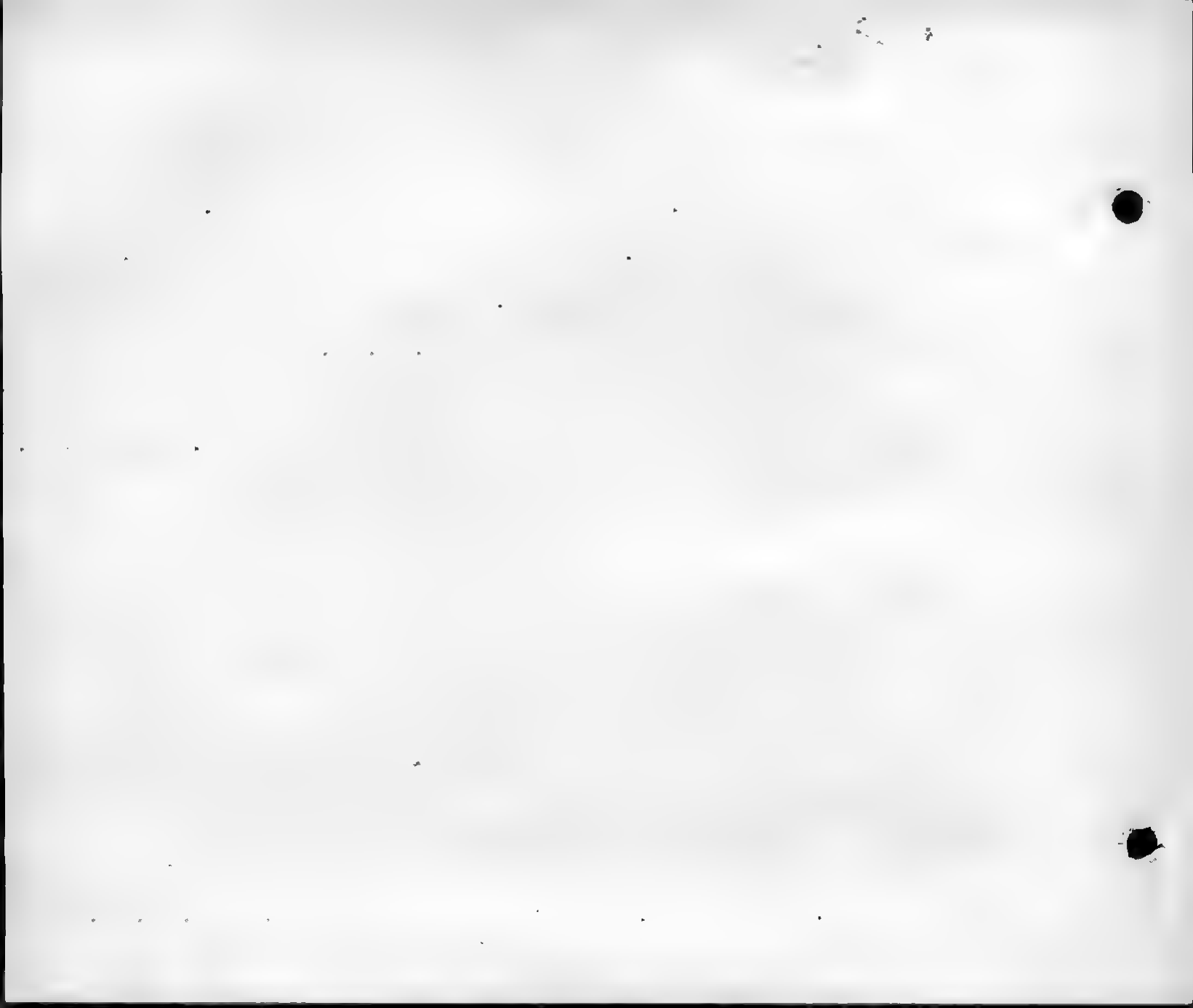
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1545

01524

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived (if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 318 Cowenton Ave.		d. STREET ADDRESS Box 318 Cowenton Ave.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Mary M. Cook		4. DATE OF DEATH Month Day Year February 5, 1961	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 26, 1883
9 AGE (In years last birthday) 77 yrs		F UNDER 1 YEAR IF UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME George Kahl		14. MOTHER'S MAIDEN NAME Mary Funnkas	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. None	
17. INFORMANT Address Joseph Cook Box 318 Cowenton Ave. Fullerton, Md.			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X Cerebro-Vascular accident DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 4, 1961 to Feb 5, 1961 that (I) (we) last saw the deceased alive on Feb 5, 1961, and that death occurred at 10 AM, from the causes and on the date stated above			
22a SIGNATURE M. D. M. Baumgardner		22b. DATE SIGNED	
22c PHYSICIAN'S NAME (Type) Balto 6 Md		22d ADDRESS	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Feb. 9, 1961	
23c NAME OF CEMETERY OR CREMATORY St. Joseph's		23d LOCATION (City, town, or county) (State) Fullerton, Balto. Co. Md.	
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lassahn Funeral Home 7401 Belair Rd		25a REC'D BY REGISTRAR DATE FEB 7 '61	
		25b REGISTRAR'S SIGNATURE C. L. S. Evans	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1546

CERTIFICATE OF DEATH

01525

Items 8, 9, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission a. STATE MD b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PIKESVILLE		c. LENGTH OF STAY IN 1b 35 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 110 SHERWOOD AVE.		e. STREET ADDRESS 110 SHERWOOD AVE	
3. NAME OF DECEASED (Type or print) BLANCHE CAROLINE COULSON		4. DATE OF DEATH FEBRUARY 4 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1896 MARCH 21 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE CHUNK		14. MOTHER'S MAIDEN NAME CECELIA MCKIM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MR. GEORGE P. COULSON, 1013 KINGSTON RD. PIKESVILLE		Address RD. PIKESVILLE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma probably renal origin			
180X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
(b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 10 1961 to Feb 4 1961 , that (I) (we) last saw the deceased alive on Feb 4 1961 , and that death occurred at 12 PM , from the causes and on the date stated above			
22a. SIGNATURE John R. Williams		22b. DATE SIGNED FEB 6 1961	
22c. PHYSICIAN'S NAME (Type) JOHN R. WILLIAMS		22d. ADDRESS Pikessville, Md.	
23a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 7, 1961	
23c. NAME OF CEMETERY OR CREMATORY DAVID RIDGE CEMETERY		23d. LOCATION (City town or county) (State) PIKESVILLE 8, MD.	
24. BURIAL OR CREMATION'S SIGNATURE Frank H. Newell, Pikessville 8		25a. REC'D BY REGISTRAR FEB 8 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



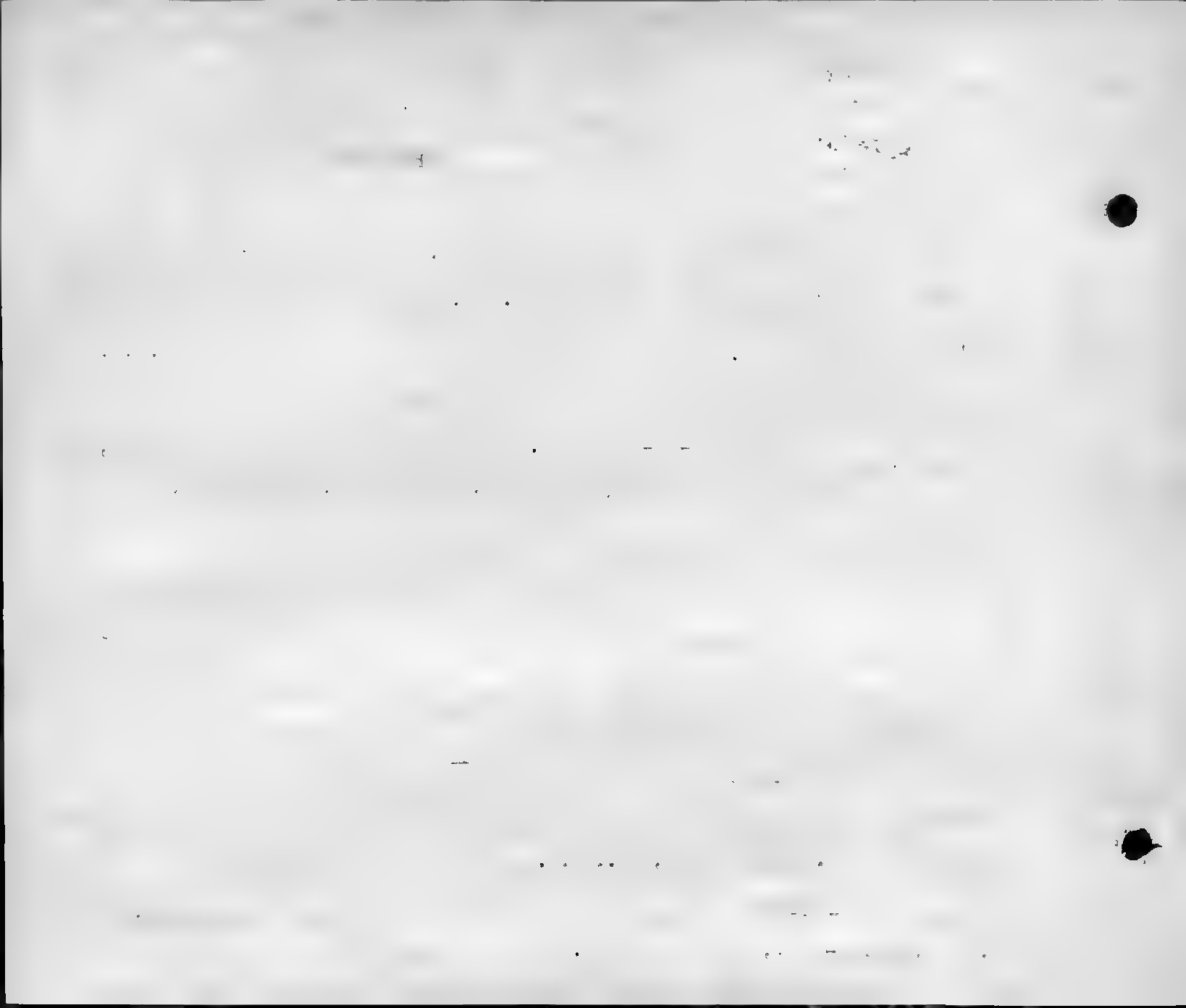
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

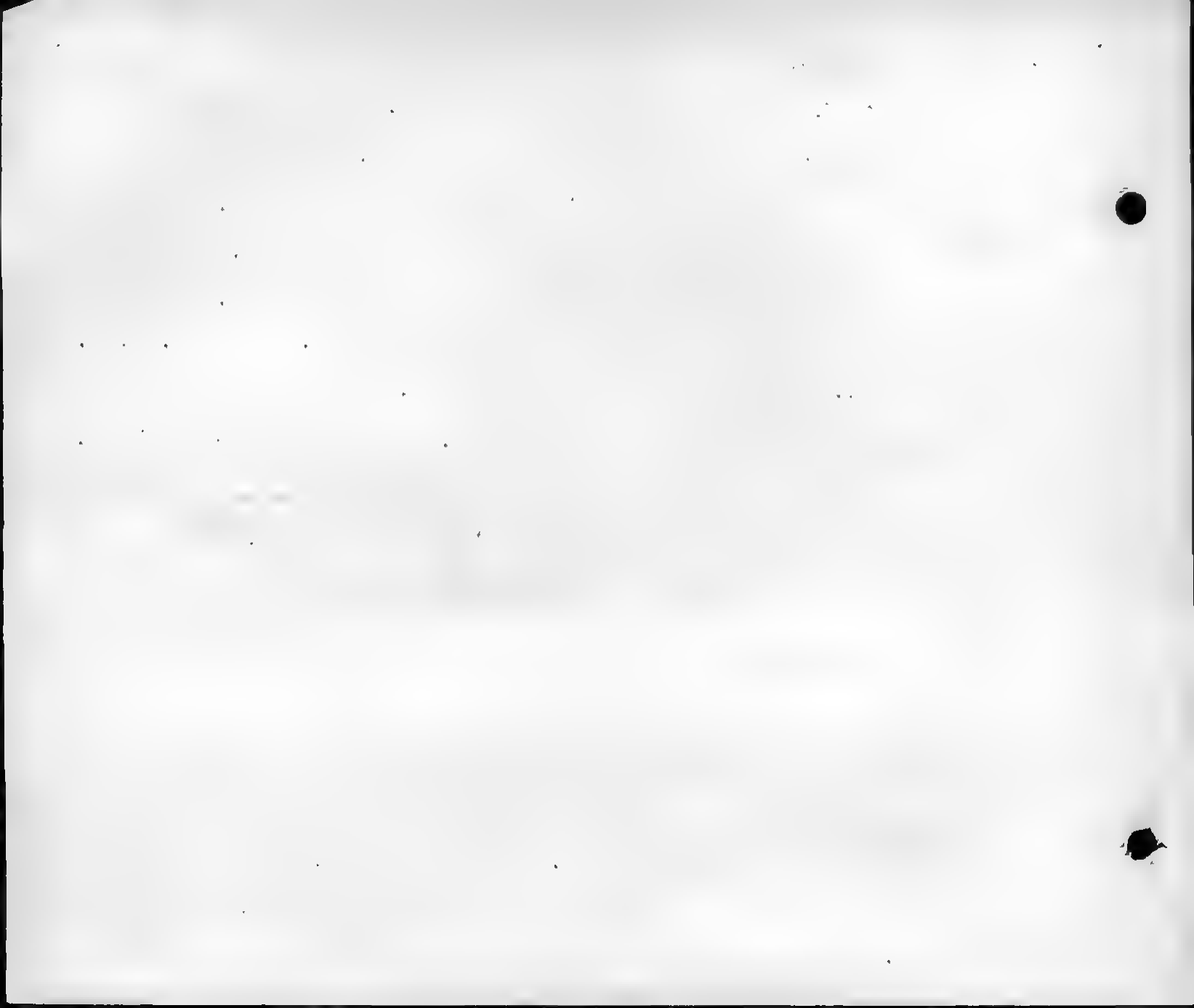
MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
1547 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Item 7 Film 6252 3-6-61 et 01526									
1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		White Marsh		c. LENGTH OF STAY IN It		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		White Marsh	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Route 2		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First JOHN		Middle JOSEPH		Last COX, JR.		4. DATE DEATH Month February Day 7 Year 1961	
5. SEX Male		6. COLOR OR RACE White		7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED		8. DATE OF BIRTH Aug. 11, 1891		9. AGE (In years last birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		(ret'd) Carpenter & E. & O employee		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		Unknown		14. MOTHER'S MAIDEN NAME		Unknown		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year and dates of service)		no		16. SOCIAL SECURITY NO.		17. INFORMANT Address		Mrs. Doris Mae Jarkov, 1709 Forrest Ave, Zone 14	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive and arteriosclerotic cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		W. Bradley King, Jr., M.D.		M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		Wm. Cook-Towson Inc., 1050 York Road, Towson 4		Address (Street, city, town, or county)		DATE SIGNED 2/8/61			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country)		(State)	
BURIAL		2-10-61		Parkwood Cemetery		3310 Taylor Avenue, Zone 14			
23. FUNERAL DIRECTOR		Wm. Cook-Towson Inc., 1050 York Road, Towson 4		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
1548 CERTIFICATE OF DEATH										
1 PLACE OF DEATH a COUNTY Baltimore MARYLAND					2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE Md. b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3433 Washington Blvd.					d. STREET ADDRESS 3433 Washington Blvd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Kenneth Alan Cox					4. DATE OF DEATH Month Day Year Feb. 7, 1961 19					
5 SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 7, 1954		9. AGE (In years last birthday) 6 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) child			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Marvin D. Cox					14. MOTHER'S MAIDEN NAME Mary C. Grace					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. none		17. INFORMANT Address Marvin D. Cox 3433 Washington Blvd. #27					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO 9 days Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Bronchial asthma DUE TO 4 (c) D. Croup 4										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										
21 I certify that (I) (this hospital) attended the deceased from Feb 6, 1961 to Feb 7, 1961 , that (I) (we) last saw the deceased alive on Feb 6, 1961 , and that death occurred at 4AM , from the causes and on the date stated above										
22a. SIGNATURE B. Brumbaugh					22b. DATE SIGNED 2/8/61					
22c. PHYSICIAN'S NAME (Type) B. Bruce Brumbaugh, M. D.					22d. ADDRESS 5609 Main St. Elkridge, 27, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/10/61		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery			23d. LOCATION (City, town or county) (State) Elkridge, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard					ADDRESS 4107 Wilkens Avenue		25a. REC'D BY REGISTRAR DATE FEB 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1
X
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1549
CERTIFICATE OF DEATH

01528

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cowings Mills</u> c. LENGTH OF STAY IN lb <u>27 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural</u> d. STREET ADDRESS <u>12X-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Raymond Dean Cox</u> First Middle Last			4. DATE OF DEATH <u>February 12 1961</u> Month Day Year				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-51</u>		9. AGE (In years lost birthday) <u>9</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Grove, Pennsylvania</u>			
13. FATHER'S NAME <u>Fred Cox</u>			14. MOTHER'S MAIDEN NAME <u>Louise Molly Isom</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Rosewood Medical Records</u> Address <u>Cowings Mills, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO (b) <u>complicating quadruplegia</u> DUE TO (c) <u>lying cause lost</u>					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 16</u> 1961, to <u>Feb 12</u> 1961, that (I) (we) last saw the deceased alive on <u>Feb 12</u> 1961, and that death occurred at <u>10 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>W. Rieckert</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>2-13-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. Rieckert</u>		22d. ADDRESS <u>4307 Mainfield Rd. Balt'd</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>Feb. 14, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Vaughan-Gwynn F.H.</u>			
23d. LOCATION (City, town or county) (State) <u>Galax Virginia</u>		25a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u> DATE <u>FEB 15 '61</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Mc Comas & Son</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>					

Howard K. Mc Comas & Son Abingdon, Md.,



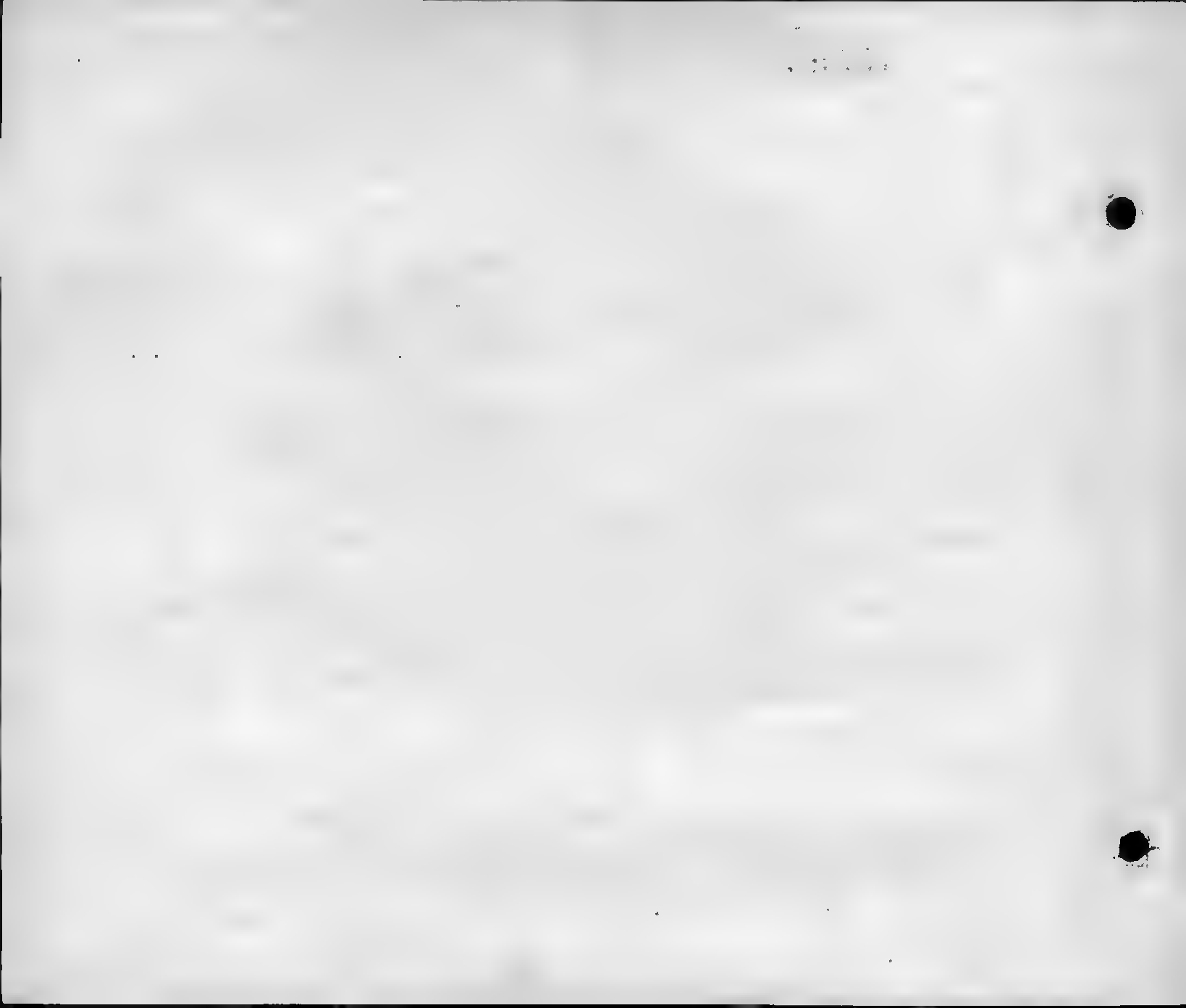
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1550 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01529

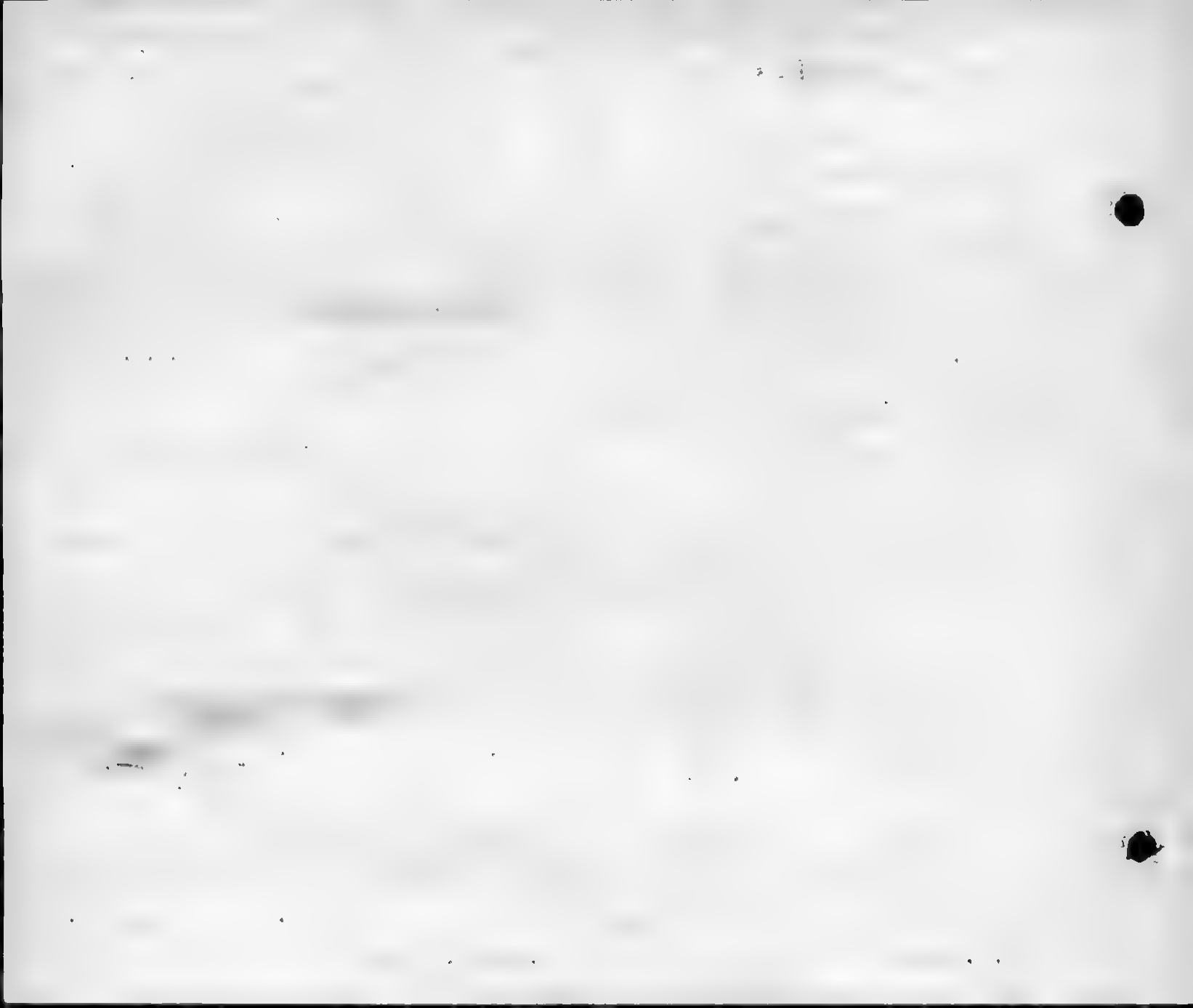
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> c. LENGTH OF STAY IN TB <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>109 Avondale Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>/</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> d. STREET ADDRESS <u>109 Avondale Road</u>	
3. NAME OF DECEASED (Type or print) <u>Rene</u> First Middle Last 4. DATE OF DEATH <u>Feb 13 1961</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct. 1, 1959</u> 9. AGE (in years last birthday) <u>1</u> yrs. IF UNDER 1 YEAR: Months <u>12</u> Days <u>12</u> IF UNDER 24 HRS: Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NO</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NO</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Otis Crockett</u>		14. MOTHER'S MAIDEN NAME <u>Viola James</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Viola Crockett - 109 Avondale Road</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1-2-3 Burns over entire body</u> DUE TO (b) <u>NO</u> DUE TO (c) <u>NO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>None</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>Burned to death in house fire</u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned to death in house fire</u>		20c. TIME OF INJURY Month, Day, Year <u>11:15 p.m. 2/13 1961</u>	
20d. INJURY OCCURRED <u>at work</u> <input type="checkbox"/> <u>Not at work</u> <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. CITY or town <u>Baltimore</u> (State) <u>Md</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
SIGNATURE <u>M. B. Davis</u> EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2/16/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-17-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR <u>Charles R. Law</u> ADDRESS <u>802 Madison Avenue</u>		24a. REC'D BY REGISTRAR <u>FEB 17 '61</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. This permit must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1551					01530									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN b <u>47yr2mo15da</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2651 Greenmount Av.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Mary Elizabeth Curran</u>					4. DATE OF DEATH Month <u>February</u> Day <u>27</u> Year <u>1961</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 6, 1870</u>		9. AGE (In years last birthday) <u>90</u> yrs						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Orig. Music Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>						
13. FATHER'S NAME <u>Joseph A. Curran</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Williamson</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>-</u>					17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> <u>450</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Advanced mental disease and senility</u> (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u> <u>months</u> <u>years</u> <u>years</u>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 13, 1960</u> to <u>Feb. 27, 1961</u> that (I) (we) last saw the deceased alive on <u>Feb. 27, 1961</u> , and that death occurred at <u>7:20 A.M.</u> from the causes and on the date stated above.														
22a. SIGNATURE <u>Carl H. Jenkins</u> M.D.					22b. ADDRESS <u>Spring Grove State Hospital Catonsville 28, Maryland</u>					22c. DATE SIGNED				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3-1-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>					23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u>					25a. REC'D BY REGISTRAR <u>4905 York Rd. Balto.</u>					25b. REGISTRAR'S SIGNATURE <u>DATE MAR 1 '61</u>				



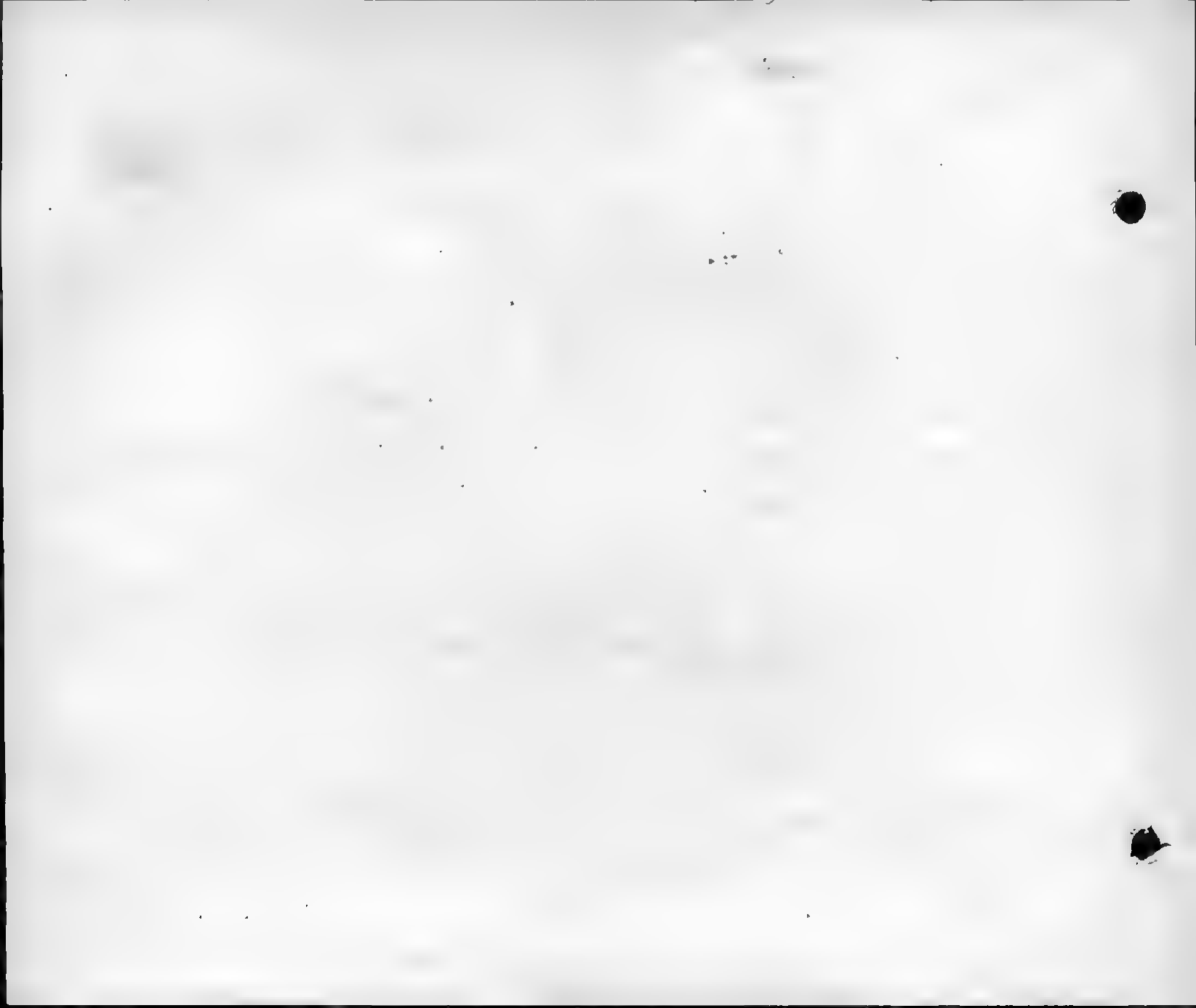
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1552

01551

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anneslie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anneslie			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 712 Murdock Road				d. STREET ADDRESS 712 Murdock Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Mary Clark Dahlmer				4. DATE OF DEATH Month Day Year February 11 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 30, 1883		9. AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Julius Demme				14. MOTHER'S MAIDEN NAME Mary C. Kochler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Ruth D. Benson-712 Murdock Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): CARCINOMA OF COLON 153.8 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) NONE					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 28 1960 to Feb 11 1961 , that (I) (we) last saw the deceased alive on October 28 1960 , and that death occurred on Feb 11 1961 AM, from the causes and on the date stated above.							
22a. SIGNATURE A.S. Chalfant				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) A.S. CHALFANT				22d. ADDRESS 6210 YORK ROAD, BALTO. 12.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 13, 1961		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tuckner - Sons				25a. REC'D BY REGISTRAR DATE FEB 14 1961		25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1553

01552

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MD b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) CATONSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 307 Harlem Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First J. Middle ROGER Last DAVIS				4. DATE OF DEATH Month FEB. Day 6 Year 1961			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 2, 1902	
9. AGE (In years last birthday) 58 yrs		IF UNDER 1 YEAR Months 5 Days 1 Hours 1 Min 1		IF UNDER 24 HRS Hours 1 Min 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist				10b. KIND OF BUSINESS OR INDUSTRY Chemical Co.		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? MD							
13. FATHER'S NAME John R. Davis				14. MOTHER'S MAIDEN NAME Marian G. McSwain			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Mrs. J. Roger Davis - 307 Harlem Lane Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CAARCINOMA OF URINARY BLADDER WITH METASTASES TO LIVER</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</p> <p>(b) _____ DUE TO _____</p> <p>(c) _____</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 19 60 to 2/6/61 , that (I) was last saw the deceased alive on 2/5/61 and that death occurred 4:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE W.E. McGrath				22b. DATE SIGNED 2/8/61			
22c. PHYSICIAN'S NAME (Type) W.E. McGrath				22d. ADDRESS 1303 Frederick KRL (28)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		2-9-61		Landonville Cem		Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Harley Canning B.F.H. - Catonsville, Md.				25a. REC'D BY REGISTRAR DATE FEB 10 '61		25b. REGISTRAR'S SIGNATURE C. J. S. Thomas	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Reg. Dist. No. 01557

MEDICAL CERTIFICATION

O HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1555

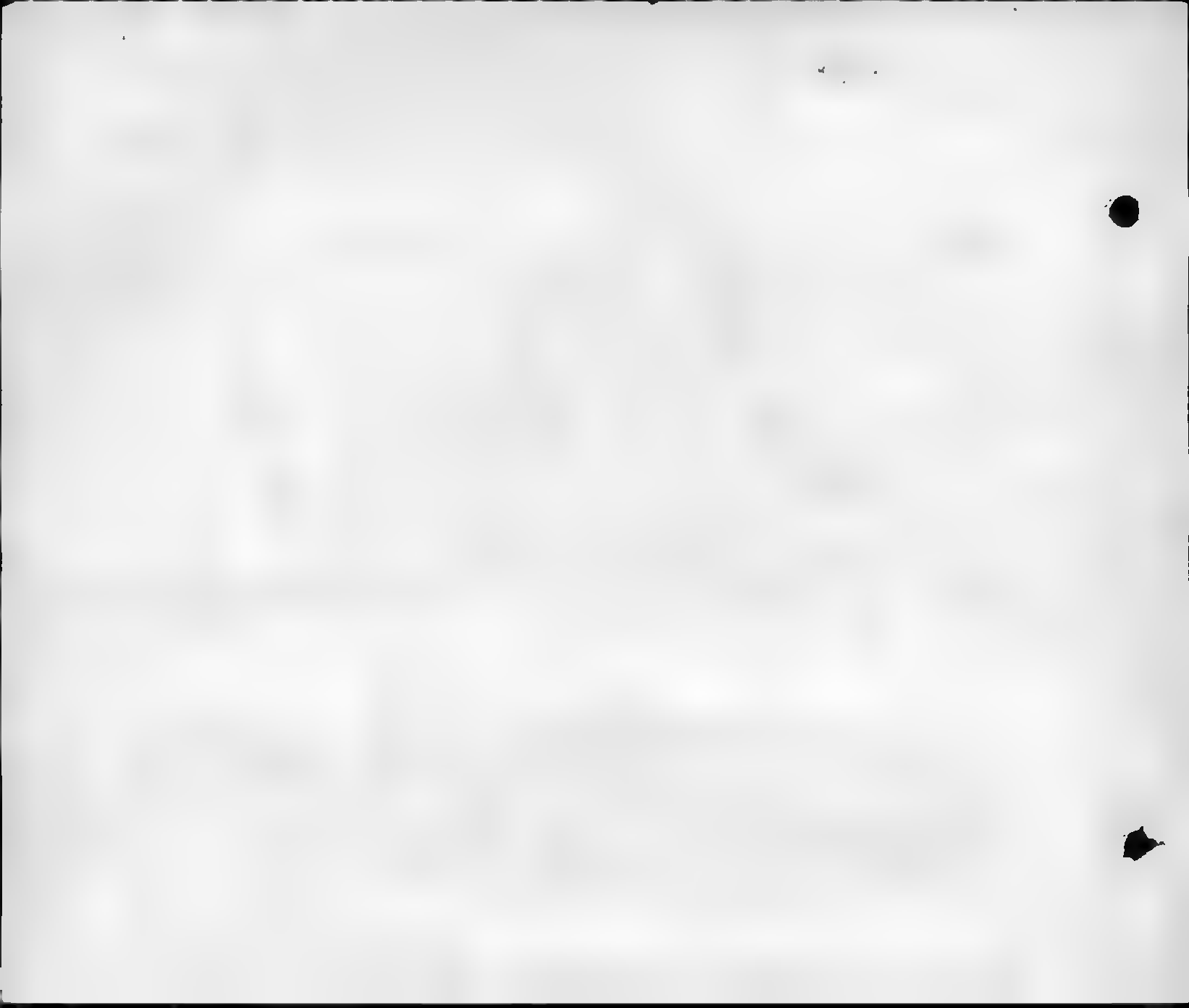
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01534

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>				c. LENGTH OF STAY IN 1b <u>EDGEWATER</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7215 RIVERDRIVE RD.</u>				d. STREET ADDRESS <u>17215 RIVERDRIVE RD</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Alexander</u> Last <u>Day</u>				4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 27-1914</u>	9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HEATER DEPT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RITEEM CO</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOHN C. DAY</u>				14. MOTHER'S MAIDEN NAME <u>CHARLOTTE FRAZIER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>120</u>		17. INFORMANT Address <u>VIRGINIA HASEY 2618 MASETH AL</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bronchial Asthma</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack E. Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Jack E. Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/13/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SAINT JOHN</u>		22d. LOCATION (City, town, or county) (State) <u>COLGATE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM FUNERAL HOME - DUNDALK</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Christina L. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01535

1. PLACE OF DEATH a. COUNTY Baltimore Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Freeland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Oakland Rd.		d. STREET ADDRESS 3139 Tilden Drive	
3. NAME OF DECEASED (Type or print) First Middle Last Preston Robert Day		4. DATE OF DEATH Month Day Year Feb. 25 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1907
9. AGE (In years last birthday) 53 1/2 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No Yes		16. SOCIAL SECURITY NO. 218-03-2106	
17. INFORMANT Bortner C. Day		Address 619 W. 33rd. St. Balto. 11, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Alcoholism DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE A.M. France		DATE SIGNED 2/25/61	
EXAMINER'S NAME (Type) A.M. France		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 1, 61	22c. NAME OF CEMETERY OR CREMATORY Baltimore Nat.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Chenoweth Jr. 3617 Chestnut Ave		24a. REC'D BY REGISTRAR DATE 24b. REGISTRAR'S SIGNATURE Arthur S. French	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



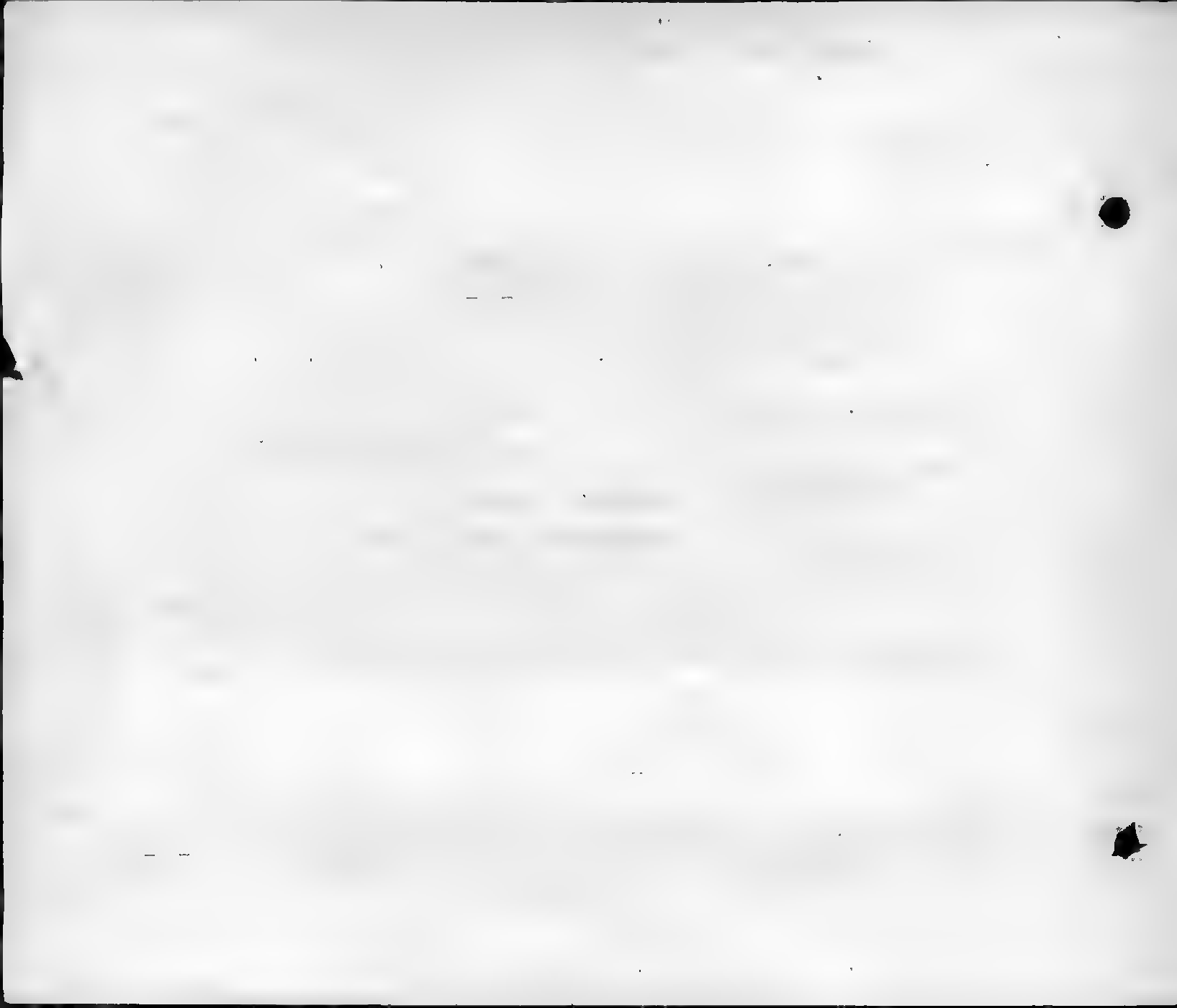
1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1557 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01536

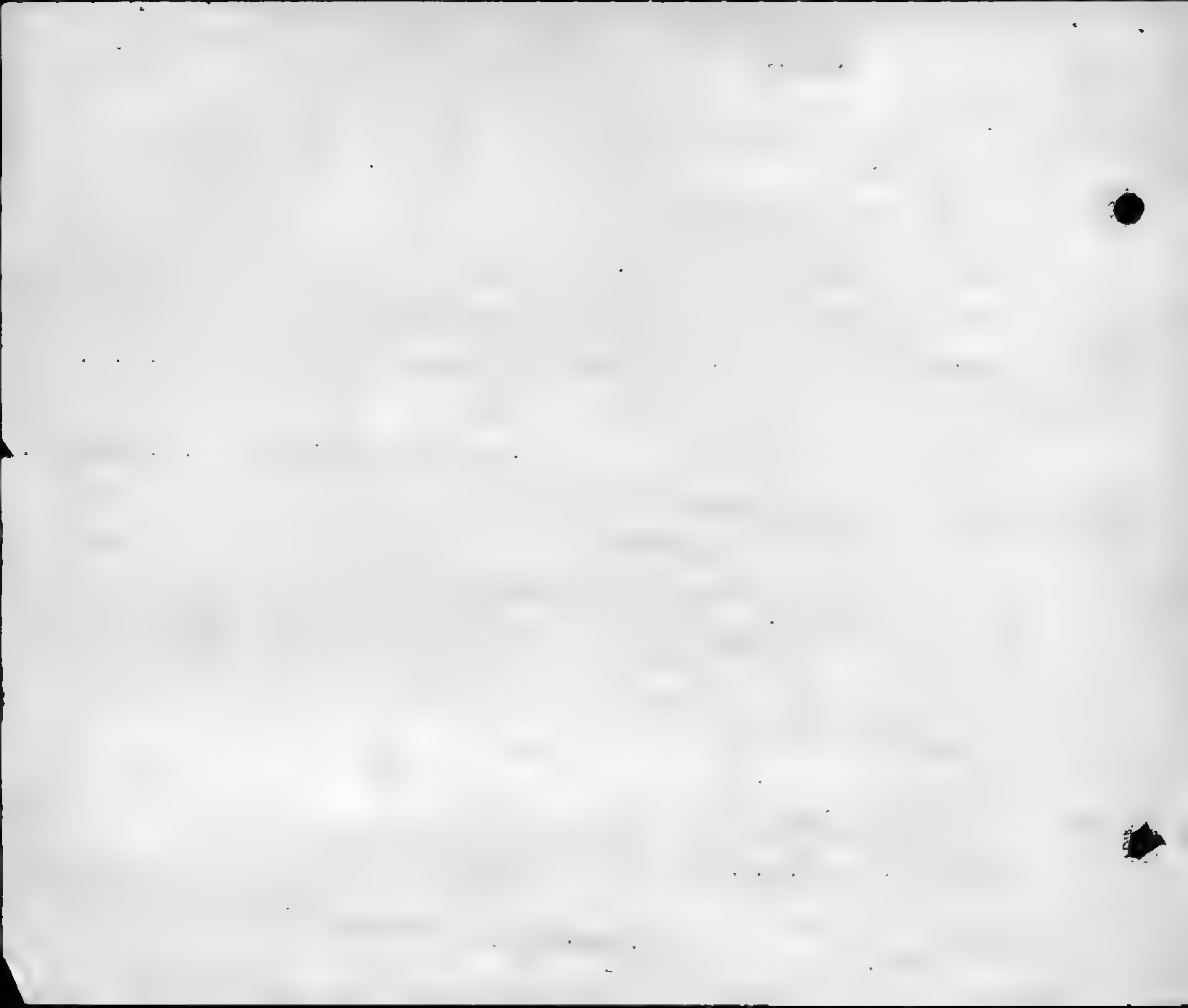
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Box 269 Belair Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Clinton Debaugh Jr.		4. DATE OF DEATH Month Day Year Feb 23 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-30-22
9. AGE (in years last birthday) 38 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Mins
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Maker		10b. KIND OF BUSINESS OR INDUSTRY The Martin Co	
11. BIRTHPLACE (State or foreign country) Baltimore Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph C. De Baugh, Sr.		14. MOTHER'S MAIDEN NAME Bessie Hecker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 273-16-9361	
17. INFORMANT Marian Gray Debaugh (wife) same		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 4-64 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Phlebothrombosis rt nonlital (c) 2days? DUE TO causes lost.		INTERVAL BETWEEN ONSET AND DEATH mins	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John C Hyle		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/61	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Rack		24a. REC'D BY REGISTRAR DATE FEB 27 '61	
ADDRESS 5305 Harford Road #14		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



01552

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01558

1559

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson	c. LENGTH OF STAY IN 1b 16 yr	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland		d. STREET ADDRESS 415 Rosecroft Terrace 29	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle F. Last DICKENS		4. DATE OF DEATH Month 2 Day 8 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20 1881
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months 7 Days 9 Hours 19 Min 61	IF UNDER 24 HRS Months 7 Days 9 Hours 19 Min 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterman's Asst.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Forryth Co. N. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Dickens		14. MOTHER'S MAIDEN NAME Ellen Farrington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 225-07-3068	
17. INFORMANT Deceased (self)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Tuberculosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 16 yr 16 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 2 19 65 , to Feb 8 19 61 , that I last saw the deceased alive on Feb 3 19 61 , and that death occurred at 5:25 A. M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Milton B. Kress		M.D.	
PHYSICIAN'S NAME (Type) MILTON B. KRESS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-11-61	22c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Norfolk, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tucker & Sons		24a. REC'D BY REGISTRAR DATE FEB 14 '61	
ADDRESS Balto 17, Md		24b. REGISTRAR'S SIGNATURE Wm J. Tucker	

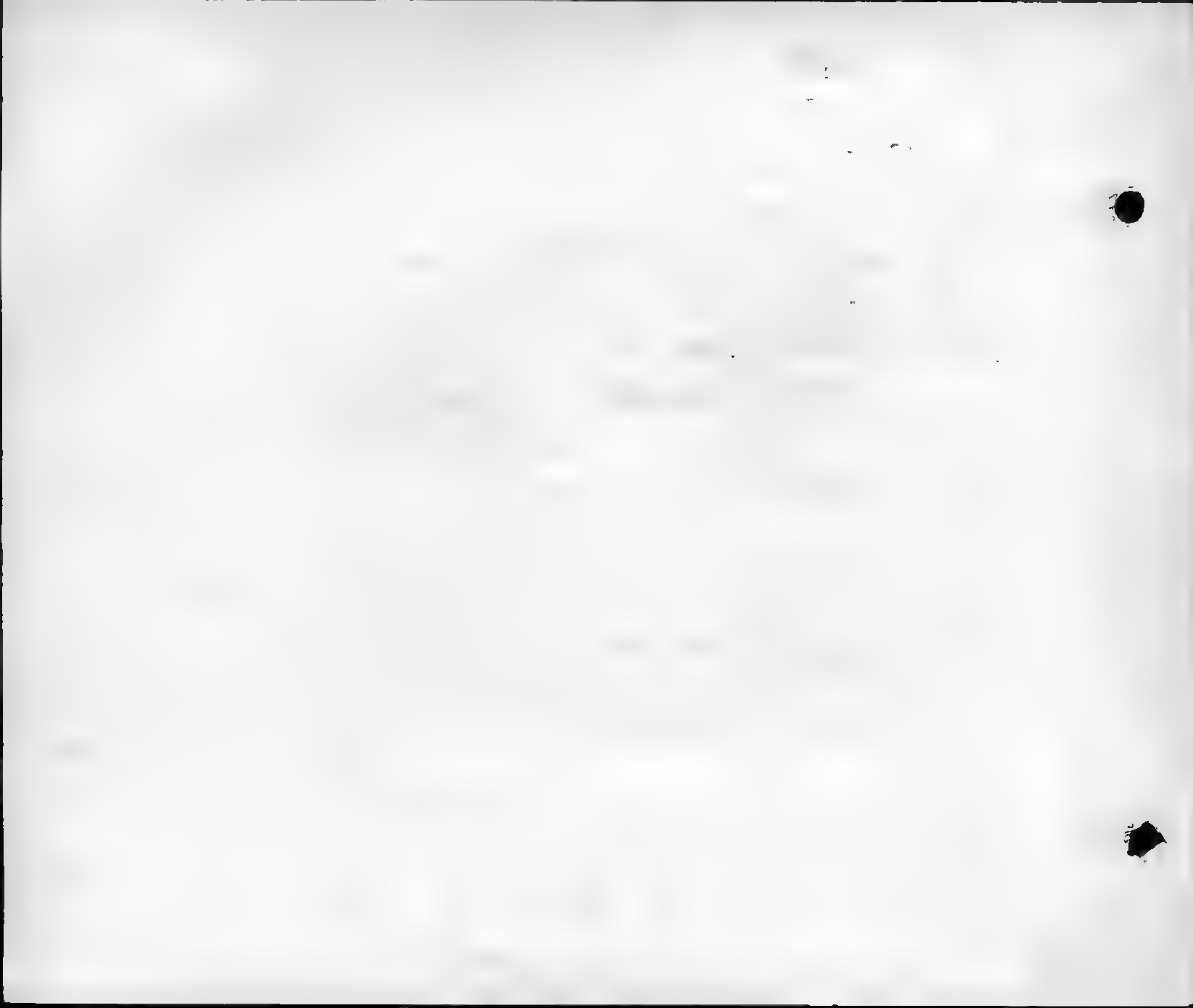
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Page 4 of 4
#1
X
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4
1560
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
01533

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE MD. b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CATONSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 400 GREENLOW RD.		d. STREET ADDRESS 129 OVERBROOK RD.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) JOHN J. DIEFENBACH		4. DATE OF DEATH FEB. 10, 1961	
5 SEX M.	6 COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH OCT. 19, 1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CLERK B&O R.R.		10b. KIND OF BUSINESS OR INDUSTRY MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DIEFENBACH		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16 SOCIAL SECURITY NO	
17. INFORMANT MR. JOHN J. DIEFENBACH JR.		Address 400 GREENLOW RD. #28, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatous Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. BRONCHOGENIC CARCINOMA DUE TO (b) BRONCHOGENIC CARCINOMA DUE TO (c) BRONCHOGENIC CARCINOMA		INTERVAL BETWEEN ONSET AND DEATH Apr. 1960	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from May 3, 1957 , to Feb 10, 1961 , that (I) was last saw the deceased alive on Feb 10, 1961 , and that death occurred at 9:15 PM , from the causes and on the date stated above			
22a. SIGNATURE Harry L. Knipp		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) HARRY L. KNIPP, M.D.		22d. ADDRESS 4116 Edmondson Ave., Balto. 29, Md.	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 14/61	
23c. NAME OF CEMETERY OR CREMATORY LOUDON PK. CEM.		23d. LOCATION (City, town, or county) (State) BALTO. MD.	
24 FUNERAL DIRECTOR'S SIGNATURE WITZKE FUN. DIR. 401 EDMONDSON		25a. REC'D BY REGISTRAR FEB 14 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	



1561

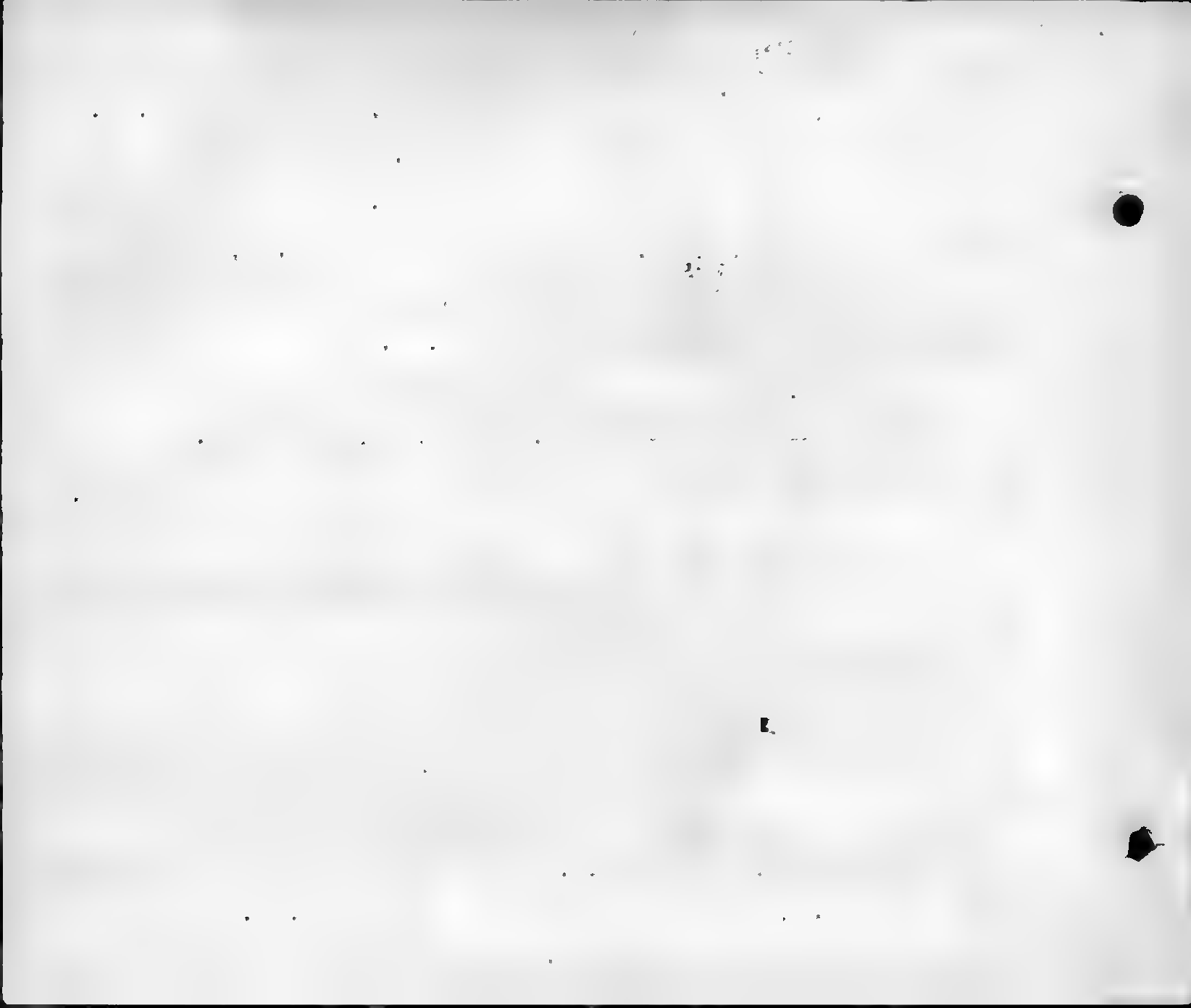
CERTIFICATE OF DEATH

Reg. Dist. No.

01540

1. PLACE OF DEATH a. COUNTY 8045 Phila Rd. Balto. Co MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE 8045 Phila Rd. b. COUNTY Balto. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 8045 Phila Rd. 6	
3. NAME OF DECEASED (Type or print) LeRoy W. Dill Sr.		4. DATE OF DEATH Month Feb. Day 13 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Clerk		10b. KIND OF BUSINESS OR INDUSTRY Towson Corut Hose	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George W. Dill		14. MOTHER'S MAIDEN NAME Louise Duckhart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. 217-09-6702A	
17. INFORMANT Mrs. Adella E. Dill		Address 8045 Phila Rd. 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH Immed. 5 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 7 Feb 61	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1954 to Feb 13 , 19 61 , that I last saw the deceased alive on 7 Feb 61 , 19____, and that death occurred at 11:30M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9660 Belair Rd Balto 6 Md DATE SIGNED 2/14/61			
ACTUAL SIGNATURE George D. Edwards PHYSICIAN NAME (Type) GEORGE D. EDWARDS, M.D.		M.D. 9660 Belair Rd Balto 6 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 16, 1961	22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Philip H. Hargrave		24a. REC'D BY REGISTRAR DATE FEB 16 '61	24b. REGISTRAR'S SIGNATURE Charles S. Hines

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and in any event within 72 hours after death.



may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

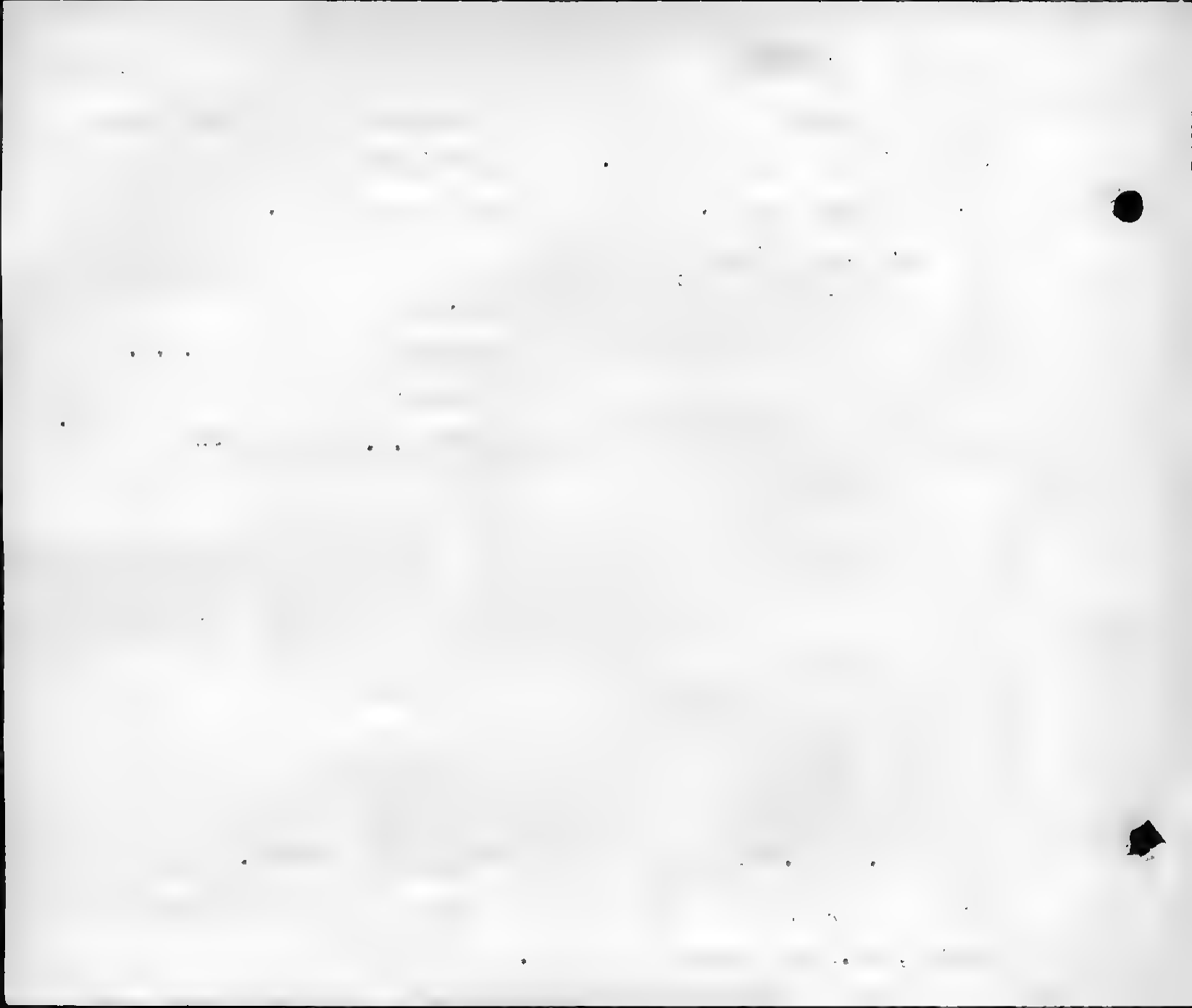
1562

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01541

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
c. LENGTH OF STAY IN 1b 3 Yrs.		d. STREET ADDRESS 5700 Johnnycake Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5700 Johnnycake Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frederick Dimpert		4. DATE OF DEATH February 19, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1887
9. AGE (in years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Warehouse	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Elizabeth L.D. Dimpert	
17. INFORMANT Elizabeth L.D. Dimpert		Address 5700 Johnnycake Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Burkholder's Carcinoma DUE TO 162.01 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic obstructive Heart Disease & Carcinoma of Prostate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 8/1 , 19 60 , to 2/19 , 19 61 , that (I) (we) last saw the deceased alive on 1/16 , 19 61 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Max J. Miller		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Max J. Miller		22d. ADDRESS 1047 Ingleside Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/22/61	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town, or county) (State) Dorsey, Howard, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ambröse, Inc. 1328 Sulphur Spring Rd.		25a. REC'D BY REGISTRAR FEB 21 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1448

Item 4 Film 0281 2-20-61 et

01543

1. PLACE OF DEATH a. COUNTY BALTO b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD. b. COUNTY BALTO	
3. NAME OF DECEASED (Type or print) First GEORGE Middle L Last DORSEY		4. DATE OF DEATH Month February Day 12 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 28, 1898
9. AGE (In years last birthday) 63 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAPTAIN-RET.		10b. KIND OF BUSINESS OR INDUSTRY FIRE DEPT.	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME GEO. W. DORSEY		14. MOTHER'S MAIDEN NAME THERESA E. MAGAHA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO.		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Geo L. Dorsey-1305 Dorchester Rd		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE ARTERIO-SCLEROTIC DUE TO PARVA-VASCULAR DISEASE (c) PARVA-VASCULAR DISEASE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/1 19 61 to 2/12 19 61 , that (I) (we) lost the deceased on 2/12 19 61 , and that death occurred at 8:45 PM , from the causes and on the date stated above			
22a. SIGNATURE John H. Shaw M.D.		22b. DATE 2/14/61	
22c. PHYSICIAN'S NAME (Type) John H. Shaw M.D.		22d. ADDRESS 5800 E. Howard Ave. Baltimore	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-16-1961	23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem	23d. LOCATION (City, town, or county) (State) Balto Md
24. FUNERAL DIRECTOR'S SIGNATURE Forly Carrington F.H. - Catonsville, Md		25a. REC'D BY REGISTRAR DATE FEB 20 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur L. Evans	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital, or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1563

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01542

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN TB <u>52 Wade Ave</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>52 Wade Ave</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>52 Wade Ave. 1</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph A. Storey</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/7/05</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Edison Railroad Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Valentine Storey</u>		14. MOTHER'S MAIDEN NAME <u>Henty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Ethel Smith Storey</u>	
17. INFORMANT <u>Ethel Smith Storey</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC</u> DUE TO <u>CAUSE</u> Conditions, if any, which gave rise to immediate cause (b) <u>CAUSE</u> (a), stating the underlying cause last. DUE TO (c) <u>CAUSE</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/2/1</u>, 19<u>60</u>, to <u>2/9</u>, 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>2/9</u>, 19<u>61</u>, and that death occurred at <u>7:15</u>, from the causes and on the date stated above.			
22a. SIGNATURE <u>John H. Shaw</u>		22b. DATE SIGNED <u>2/10/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u>		22d. ADDRESS <u>5804 Edinboro Ave. Baltimore Md.</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial 2/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall + Son</u>		25a. REC'D BY REGISTRAR <u>28</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		25c. DATE <u>FEB 14 '61</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1564

01544

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase
c. LENGTH OF STAY IN 1b Box 71
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 71

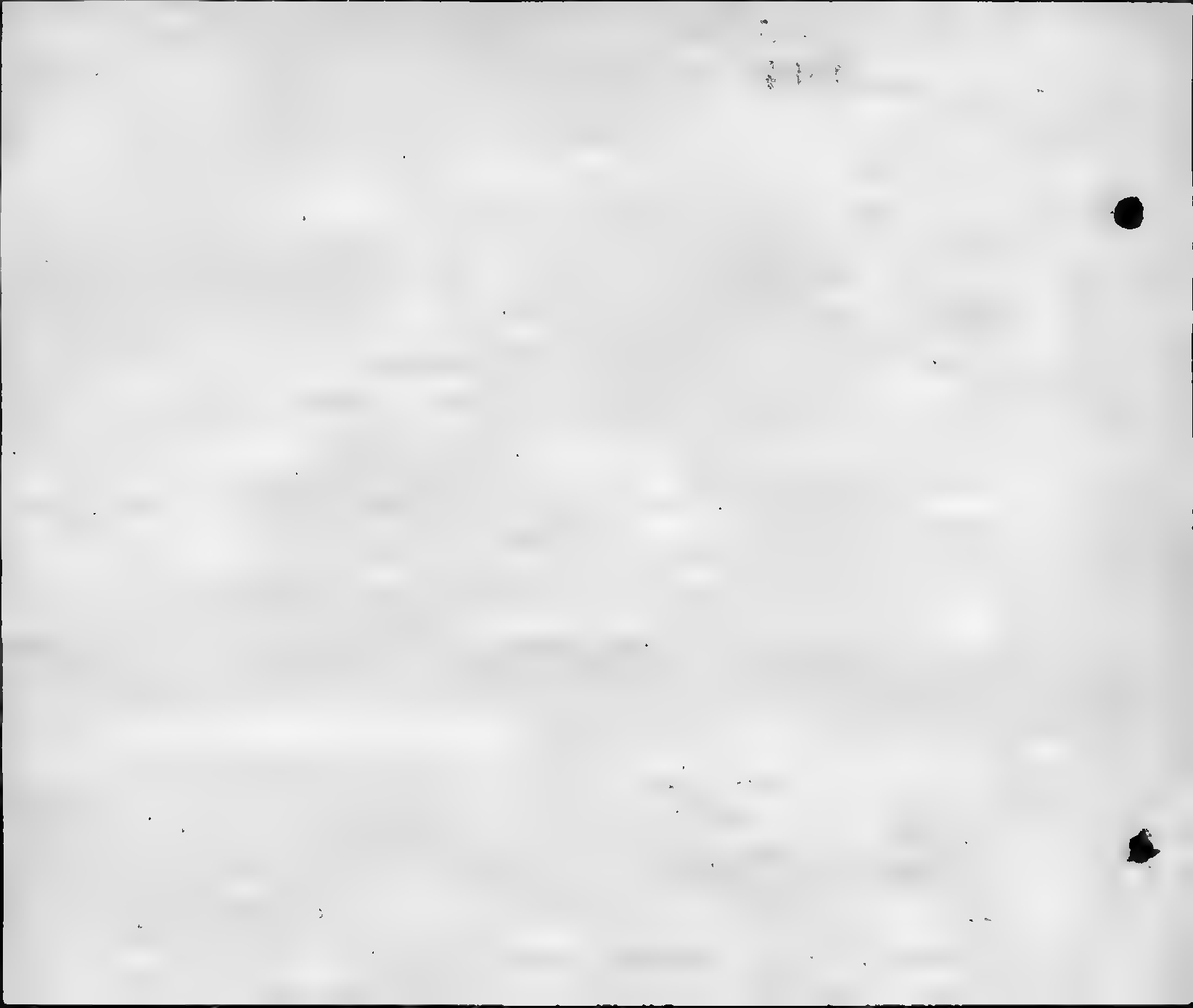
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase
d. STREET ADDRESS Box 91
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Mrs. Helen Johanna Dreyer
First Middle Last

5. SEX female 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Aug. 16, 1878 9. AGE (in years last birthday) 82 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (County & State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Henry Miller 14. MOTHER'S MAIDEN NAME Johanna Koerner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) No 16. SOCIAL SECURITY NO. Mr. Edward Dreyer 17. INFORMANT Box 71 Chase, Md. Address

18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
420 DUE TO Myocardial infarction
DUE TO Hypertension
(c) Well controlled
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) genital arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? YES ☐ NO ☒
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month 19 Day 17 Year 1961 20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Baltimore (County) Maryland (State) Md.
21. I certify that (I) (this hospital) attended the deceased from July 1, 1959 to Feb. 17, 1961 that (I) (we) last saw the deceased alive on Feb. 12, 1961 and that death occurred 4:00 p.m. from the causes and on the date stated above.
22a. SIGNATURE Donald W. Mintzer M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ DATE SIGNED Feb 17 1961
22b. SIGNATURE Donald W. Mintzer NAME (Type)
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2/20/61 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery 23d. LOCATION (City, town or county) Baltimore, Maryland (State) Md.
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5305 Harford Road #14 25a. REC'D BY REGISTRAR Feb 20 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1565

01545

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MD. b. COUNTY 100			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 3 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FOREST HAVEN				d. STREET ADDRESS 12 OVERBROOK RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CORA I. DULING				4. DATE OF DEATH Month Day Year FEB. 1, 1961			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 11, 1905		9. AGE (In years last birthday) 76 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN F. DULING				14. MOTHER'S MAIDEN NAME LAURA RUSSELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MR. RUSSELL DULING, 2 OVERBROOK RD,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL - UNSCALAR ACCIDENT 422 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last (b) ARTERIO-SCLEROTIC EPHEMERAL DUE TO (c) UNSCALAR DISEASE							INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/1 19 61 , to 2/1 19 61 , that (I) (we) last saw the deceased alive on 2/1 19 61 , and that death occurred at 15:30 PM on the causes and on the date stated above.							
22a. SIGNATURE John W. Skowron				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-25-61	
22c. PHYSICIAN'S NAME (Type) John W. Skowron				22d. ADDRESS 5800 EDGEMOOR AVE.			
23a. BURIAL CREMATION, REMOVA. (Specify) BURIAL		23b. DATE THEREOF 2/4/61		23c. NAME OF CEMETERY OR CREMATORY TERRAINE PARK		23d. LOCAT ON (City, town, or county) (State) WOODLAWN, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE WITZKE F.D.				25a. REC'D BY REGISTRAR FEB 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

TO HOSPITAL: ATTENTION: PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

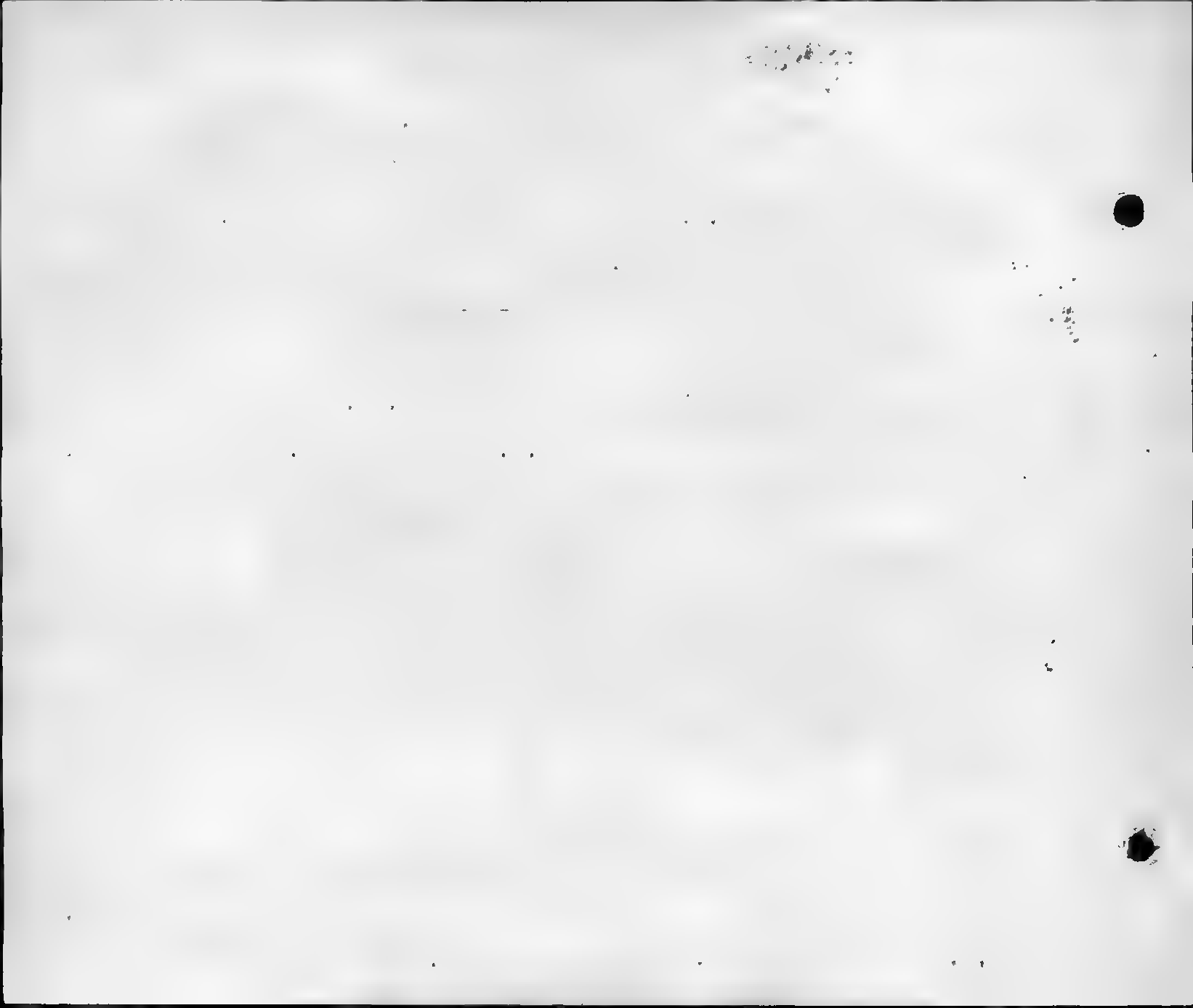
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1566

01546

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holly Hill Manor N.H.		2. USUAL RESIDENCE (Where deceased lived, if institution; Res'dance before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 217 Tunbridge Rd.	
3. NAME OF DECEASED (Type or print) Ethel C. Eby		4. DATE OF DEATH Month 2 Day 17 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-1890
9. AGE (In years last birthday) 70 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (Country & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Edward Ciscle		14. MOTHER'S M.A.DEN NAME Mary I. P. Pruiller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Mr. C. Arthur Eby Jr. 1913 Winford Rd.	
17. INFORMANT Mr. C. Arthur Eby Jr. 1913 Winford Rd.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). 175.0 no PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of ovary with generalized abdominal metastases Conditions, if any, which gave rise to immediate cause (b) 4 mos (c) INTERVAL BETWEEN ONSET AND DEATH 4 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 1960 to Feb 17 1961, that (I) (we) last saw the deceased alive on Feb 17 1961, and that death occurred at 7:11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Emmett Queen		22b. DATE SIGNED 2/20/61	
22c. PHYSICIAN'S NAME (Type) J. EMMETT QUEEN MD		22d. ADDRESS Medicine Sta Bldg	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-21-61	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City, town or county) (State) Baltimore Md.
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. 4905 York Rd. Balto		25. REC'D BY REGISTRAR FEB 21 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

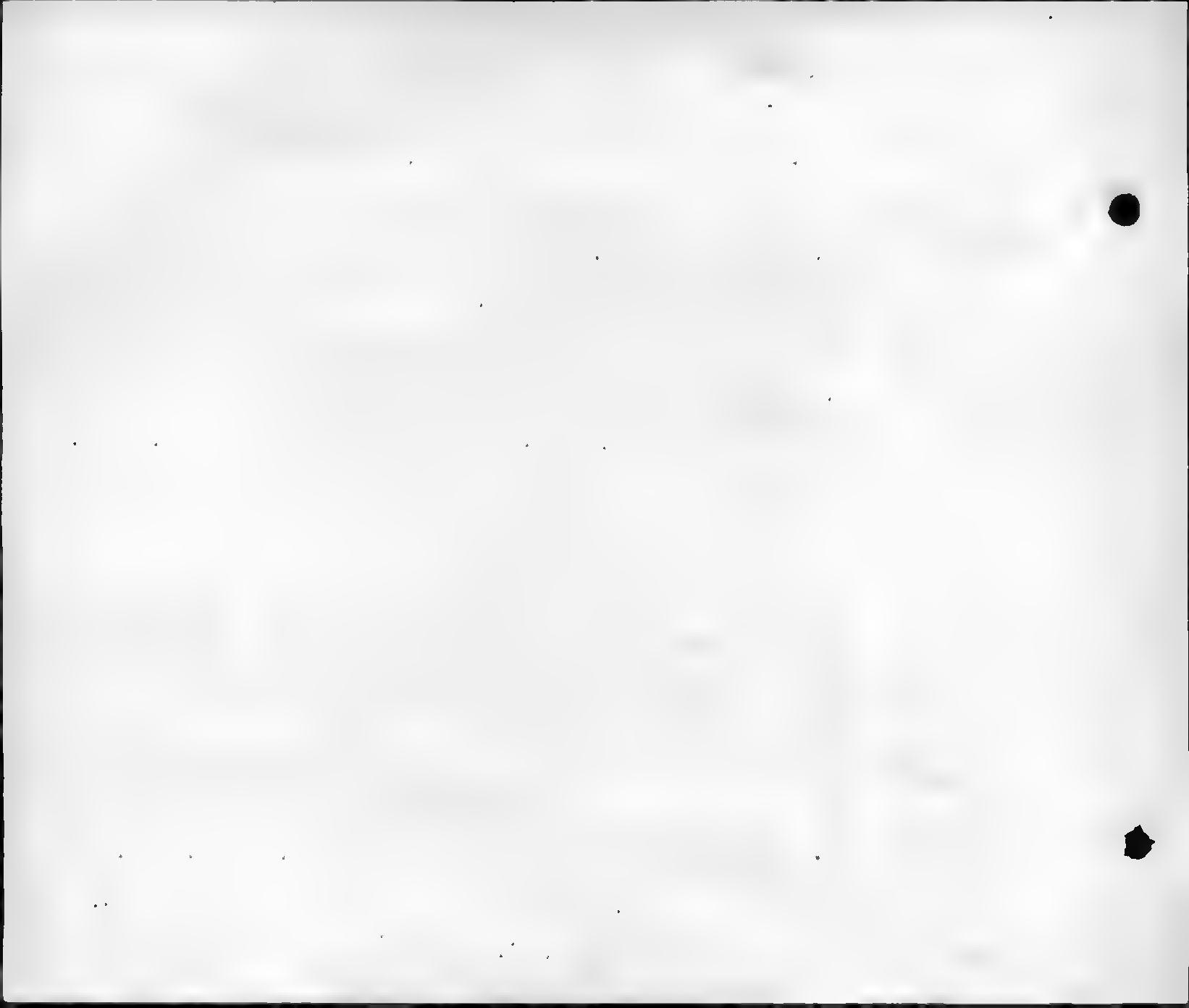


1
TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director
page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1567
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
01547

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale, Balto. 7 c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) 3620 Langrehr Road		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale, Baltimore 7 d. STREET ADDRESS 3620 Langrehr Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Mrs. Dorothy Middle M. Last Euler		4 DATE OF DEATH Month February Day 12 Year 1961	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec. 29, 1902
9. AGE (In years last birthday) 58 yrs		IF UNDER 1 YEAR Months 58 Days 12 Hours 12 Min 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) North Carolina		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Major C. Walker		14 MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO. 213-20-8345	
17. INFORMANT Mrs. Mary Luckett, 3620 Langrehr Rd. Balto. 7, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 ACUTE MYOCARDIAL INFARCTION DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 12 HOURS 10 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. 19 p. m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from SEPTEMBER 1958 to 2-12-1961 , that (I) (we) last saw the deceased alive on 2-12-1961 , and that death occurred at 6:30 AM from the causes and on the date stated above.			
22a SIGNATURE Samuel Blumenfeld		22b. DATE SIGNED 2-14-61	
22c PHYSICIAN'S NAME (Type) Dr. Samuel Blumenfeld		22d ADDRESS 2104 Gwynn Oak Ave., Balto. 7, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 2-15-1961	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION (City, town, or county) (State) Randallstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Loring Myers		25a. REC'D BY REGISTRAR 8728 Liberty Rd. Randallstown, Md.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE FEB 16 '61	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

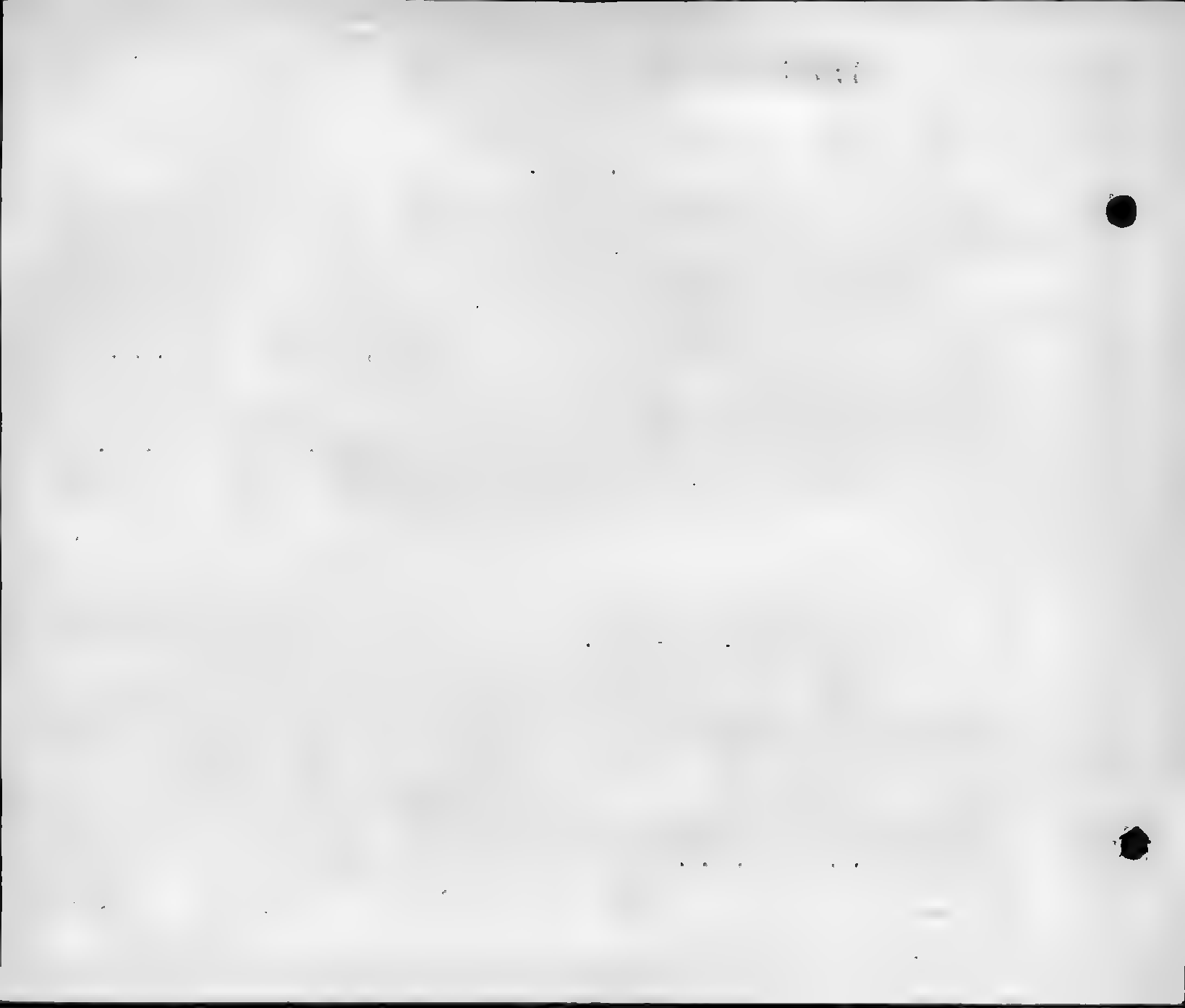
1568

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01548

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 9 yr. 11 mo.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1937 East Fairmont Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Paul		First		Middle		Last		4. DATE OF DEATH FINE		Month 2		Day 24		Year 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/14/36		9. AGE (In years last birthday) 24 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Abraham Fine		14. MOTHER'S MAIDEN NAME Dora Berman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Rosewood Records, Owings Mills, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration vomitus; due to epilepsy. 353.3 DUE TO (b) Due to epilepsy. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Mental deficiency for 9 years.												INTERVAL BETWEEN ONSET AND DEATH 10 minutes 9 yrs.					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) none		20c. TIME OF INJURY Month, Day, Year none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore		(State) Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . none CHIEF MEDICAL EXAMINER <input type="checkbox"/>																	
ACTUAL SIGNATURE D.D. Caples		EXAMINER'S NAME (Type) D.D. Caples, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2/24/61									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-61		22c. NAME OF CEMETERY OR CREMATORY Mt Carmel		22d. LOCATION (City, town, or country) Baltimore		22e. REGISTRAR'S SIGNATURE Arthur S. Harris									
23. FUNERAL DIRECTOR Jack Lewin		ADDRESS 2100 Bretar Place		24a. REC'D BY REGISTRAR DATE FEB 28 '61													

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1569

CERTIFICATE OF DEATH

01549

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY (If in hospital, give street address) <u>1835 Clearwood Road</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1835 Clearwood Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>1835 Clearwood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Josephine Fontanazza</u> First Middle Last		4. DATE OF DEATH <u>February 7th 1961</u> Date Month Day Year	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1888</u> Yrs. Months Days Min.
9. AGE (in years last birthday) <u>72</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>Mariano Tagliavia</u>		14. MOTHER'S MAIDEN NAME <u>Itana Falzone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> DUE TO (b) <u>Carcinomatous</u> DUE TO (c) <u>Carcinoma of rectum</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____			
19. INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-1-1961</u> to <u>2-7-1961</u> that (I) (we) last saw the deceased alive on <u>2-1-1961</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Lee K Farco</u> M.D.		22b. DATE SIGNED <u>2-8-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEE K FARCO</u>		22d. ADDRESS <u>8755 Loch Raven Blvd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/10/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem</u>	23d. LOCATION City, town or county (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>Feb 9 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01550**

1570

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2873 Plainfield Rd				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 2873 Plainfield Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Zona Middle Taylor Last Foster				4. DATE OF DEATH Month 2 Day 12 Year 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/4/1883		9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR: Months 78 Days 78 IF UNDER 24 HRS.: Hours 78 Min. 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY S. Carolina		11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? S. Carolina	
13. FATHER'S NAME Landrum B Taylor				14. MOTHER'S MAIDEN NAME Preshie					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. Marshall Stewart Address 2873 Plainfield Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H-S-C-V-Disease 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 422-1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Arteriosclerosis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) None	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.									
ACTUAL SIGNATURE M.B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 2/12/61	
EXAMINER'S NAME (Type) M.B. Davis M.D.				22a. BURIAL, CREMATION, REMOVAL (Specify) Removal					
22b. DATE THEREOF 2/12/61				22c. NAME OF CEMETERY OR CREMATORY Greensboro, N.C.				22d. LOCATION (City, town, or county) (State) Greensboro, N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Wm. J. Tickner William J. Tickner North & Pa. Aves						24a. REC'D BY REGISTRAR DATE 2/14/61		24b. REGISTRAR'S SIGNATURE Wm. J. Tickner	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation or removal.



TO BE FILLED BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the Medical Examiner's Office should be notified. The Medical Examiner's Office is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File (pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01551

1. PLACE OF DEATH
a. COUNTY Balt.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore

c. LENGTH OF STAY IN 1b 10 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5510 Longwood Ave

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE MD. b. COUNTY Balt.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore

d. STREET ADDRESS 5510 Longwood Ave

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print, LOUIS)

4. DATE OF DEATH Feb 3 1961

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH Jan 2, 1890

9. AGE (In years, last birthday) 71 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 M.N. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Agent

10b. KIND OF BUSINESS OR INDUSTRY Life Insurance

11. BIRTHPLACE (State or foreign country) Woodstock Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME (unknown)

14. MOTHER'S MAIDEN NAME Fort

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give number of service) No

16. SOCIAL SECURITY NO. 219-05-57

17. INFORMANT unknown Address 3311 N. Eastern Ave

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis of the brain

Conditions, if any, which gave rise to immediate cause (b) None

(c) None

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Hypertension of the blood

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐ None

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) None

20c. TIME OF INJURY Month, Day, Year Hour a.m. None p.m. None

20d. INJURY OCCURRED While at work ☐ Not While at work ☐ None

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED 2-3-61

ACTUAL SIGNATURE L.D. Caples

EXAMINER'S NAME (Type) L. D. CAPLES

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 2-6-61

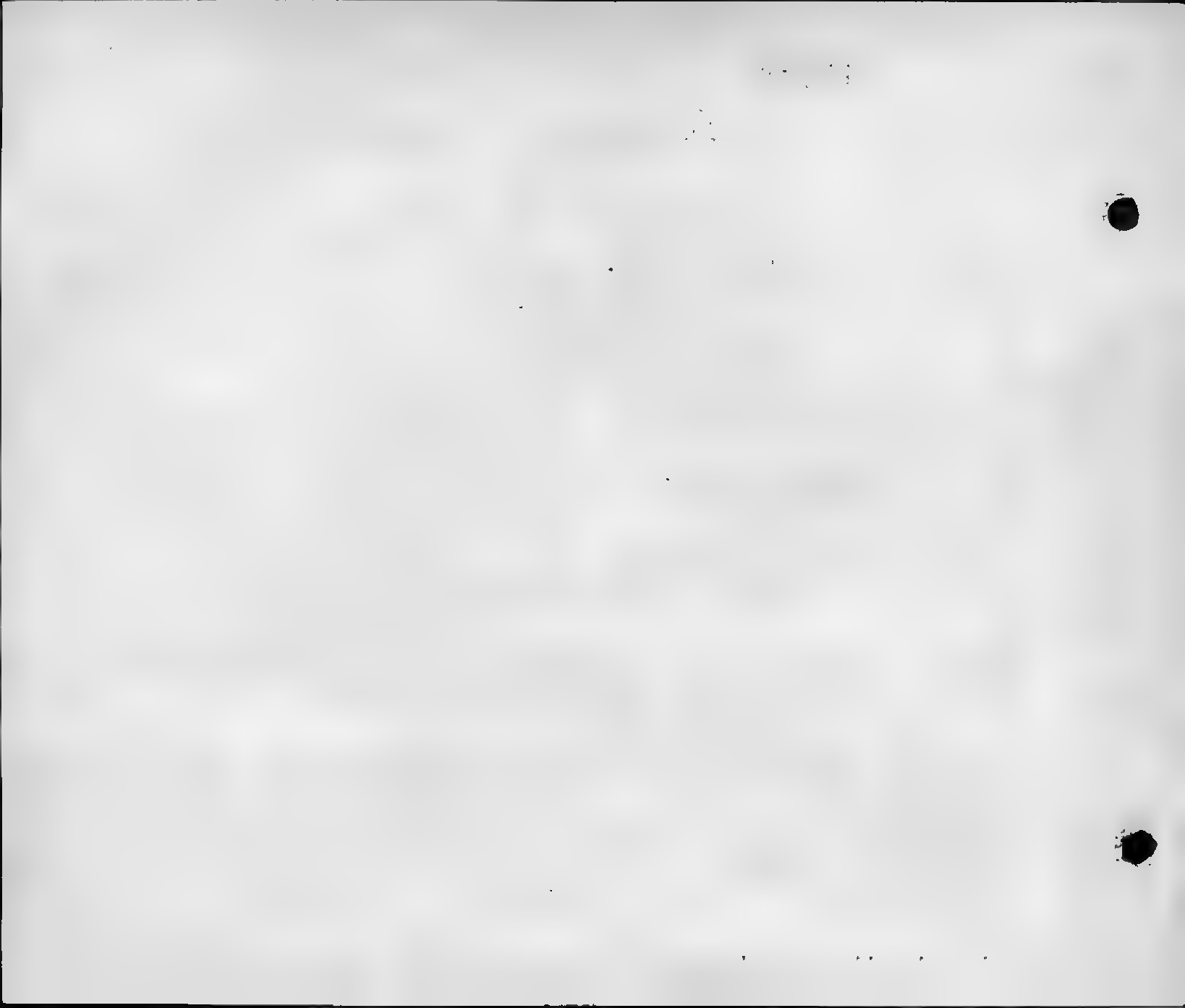
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery

22d. LOCATION (City, town, or country) (State) Baltimore

23. FUNERAL DIRECTOR Wm. Cook, Inc., 1217 St. Paul Street ADDRESS

24a. REC'D BY REGISTRAR FEB 7 '61

24b. REGISTRAR'S SIGNATURE Conrad S. Evans

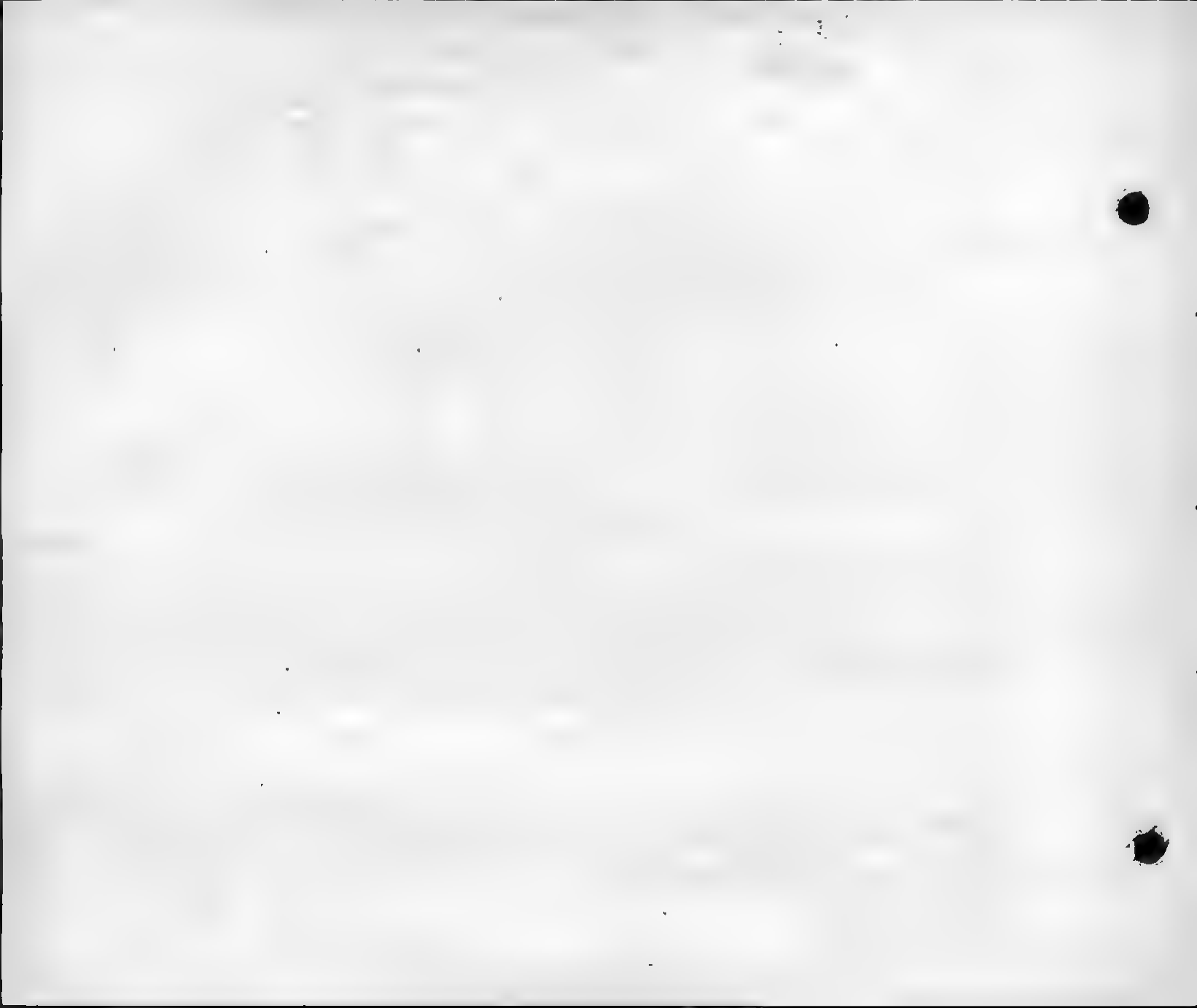


CERTIFICATE OF DEATH

Reg. Dist. No.

01553

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY 11	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 213 Sollers Point Road		e. STREET ADDRESS 213 Sollers Point Road	
3. NAME OF DECEASED (Type or print) First James Middle Carrington Last Franklin		4. DATE OF DEATH Month February Day 10 Year 1961	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1893
9. AGE (In years last birthday) 67 yrs		IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. 67	IF UNDER 24 HRS Months 67 Days 67 Hours 67 Min. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	
11. BIRTHPLACE (State or foreign country) Kent Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Franklin		14. MOTHER'S MAIDEN NAME Laura Franklin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO 213-09-2001	
17. INFORMANT Erma Franklin - 213 Sollers Point Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. February 1 - 1961 to 26/10-61 (b) Arterio-Sclerosis (c) Indefinite		INTERVAL BETWEEN ONSET AND DEATH 30 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 2-10-61 p. m. 2-10-61		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1-61 , 19 Feb 10-61 , to Feb 10-61 , that I last saw the deceased alive on Feb 10-61 , and that death occurred at 2 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. H. Thomas		ADDRESS (Street, city or town, state) 107 N. Main St. Balt. 222 1/2	
PHYSICIAN'S NAME (Type) J. H. Thomas		DATE SIGNED Feb 15 '61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-14-61	22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		ADDRESS 802 Madison Avenue	
24a. REC'D BY REGISTRAR FEB 15 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	



MEDICAL CERTIFICATION

VS A15 (4)
15M 9/5B



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

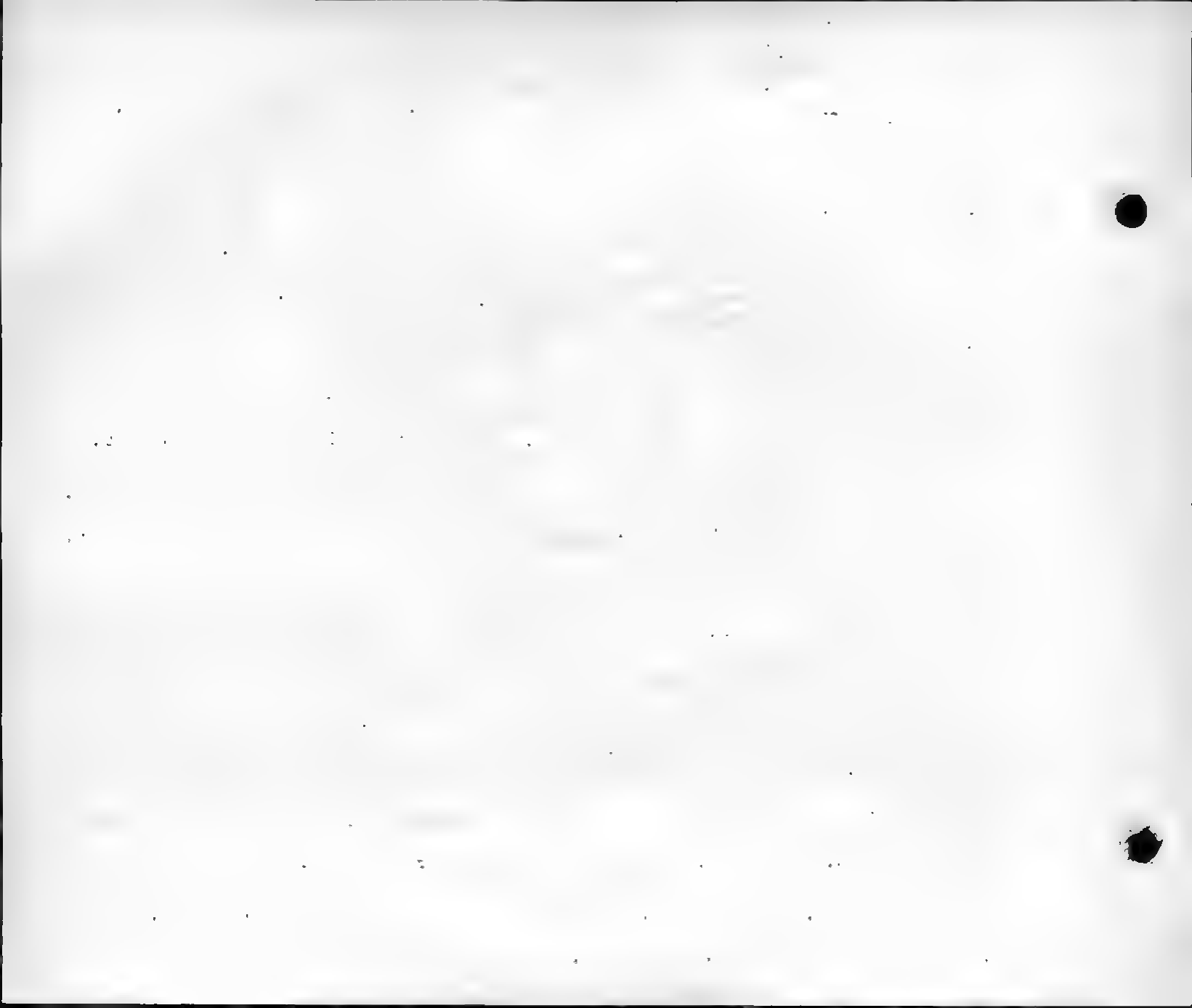
CERTIFICATE OF DEATH

Reg. Dist. No. 01554

1574

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11126 Reisterstown Road		e. STREET ADDRESS 11126 Reisterstown Road	
3. NAME OF DECEASED (Type or print) First Grace Middle May Last French		4. DATE OF DEATH Month Feb. Day 24 , Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1876
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months 84 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Nelson		14. MOTHER'S MAIDEN NAME Susan Kendig	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Charles Barnhart		Address Owings Mills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 572x IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Chronic Nephritis DUE TO (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 2 wks. 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia due to Ca. of stomach			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) none		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. none		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 12-8-41 , 19____, to 2-24-61 , 19____, that I last saw the deceased alive on 2-23-61 , 19____, and that death occurred at 5 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 2-24-61			
ACTUAL SIGNATURE D. D. Caples		M.D. 6 Hanover Rd.	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 27, 1961	22c. NAME OF CEMETERY OR CREMATORY St. Thomas	22d. LOCATION (City, town, or county) (State) Owings Mills, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR FEB 28 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

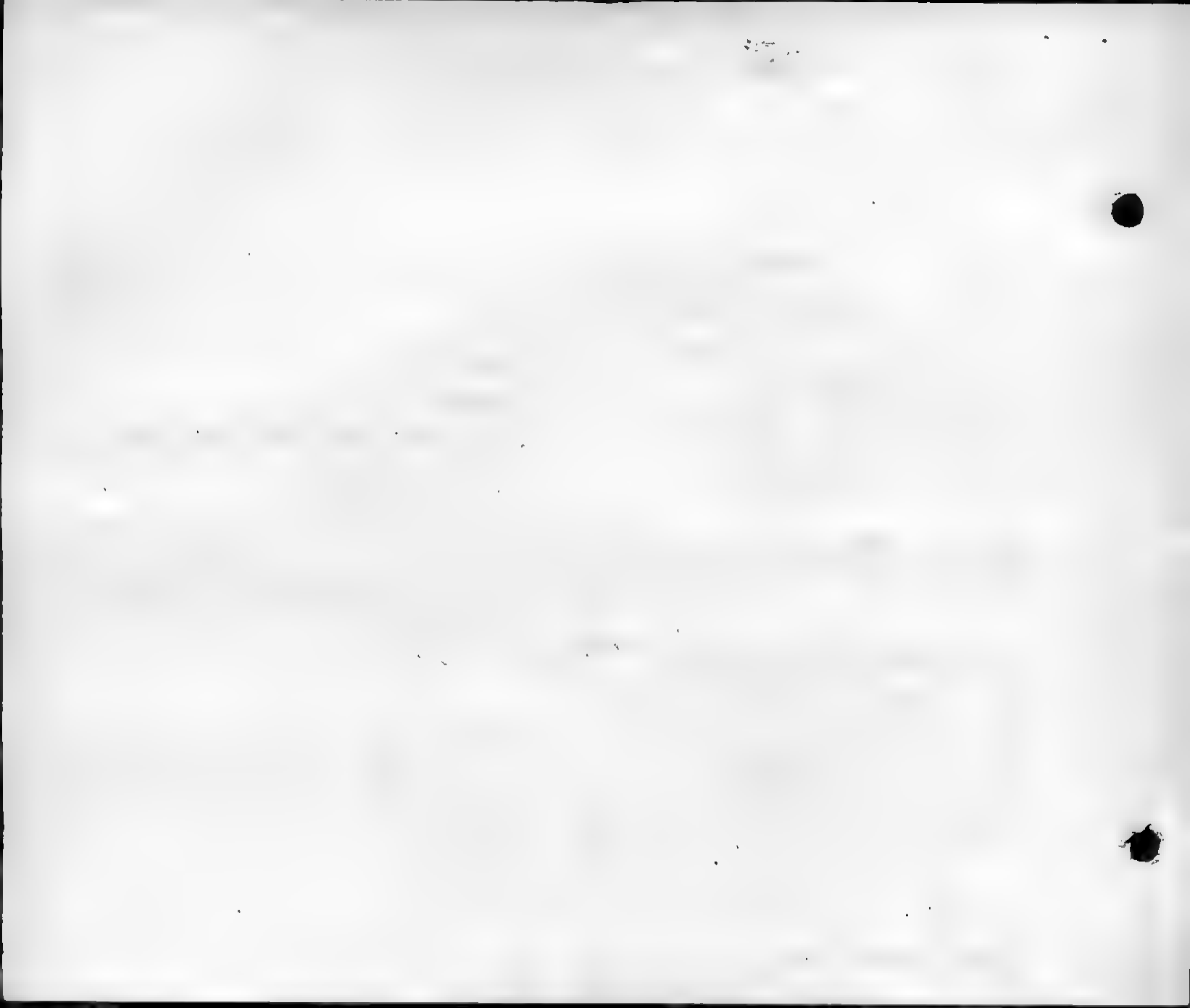
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1575

CERTIFICATE OF DEATH

01555

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines Fusting Avenue		d. STREET ADDRESS 2824 Boarman Avenue	
3. NAME OF DECEASED (Type or print) First GILBERT Middle FRUMAN Last FRUMAN		4. DATE OF DEATH Month February Day 2 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1868
9. AGE (In years lost birthday) 92 yrs		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) tailor		10b. KIND OF BUSINESS OR INDUSTRY shop	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Fruman		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO	
17. INFORMANT Address Mrs. Bessie Ballasohn- 2574 Druid Park Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction - progressive 442X DUE TO (b) Chronic Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1-2-61 103-13
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-2-1959 to 2-2-1961 , that (I) (we) last saw the deceased alive on 2-1-1961 , and that death occurred at 3:30 M, from the causes and on the date stated above.			
22a. SIGNATURE William K. Gallagher, M.D.		22b. DATE SIGNED 2-2-61	
22c. PHYSICIAN'S NAME (Type) William K. Gallagher, M.D.		22d. ADDRESS 6207 1/2 Ind. Ave., Balt 28, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 3, 1961	23c. NAME OF CEMETERY OR CREMATORY Tiferes Israel Anshe Sfard	23d. LOCATION (City or town, or county) (State) Rosedale, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc		25a. REC'D BY REGISTRAR 6010 Reist Rd	
25b. REGISTRAR'S SIGNATURE DATE FEB 6 '61		25c. REGISTRAR'S SIGNATURE Arthur S. K...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1576
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01556

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 23yr11mth13dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 2318 Federal Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Valentino Middle Gallochia Last		4. DATE OF DEATH Month February Day 17 Year 19 61	
5 SEX male	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1900
9. AGE (In years last birthday) 60 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) coal miner		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Gallochia		14. MOTHER'S MAIDEN NAME Angela DePetro	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 11, 1961 to Feb. 17, 1961 , that (I) (we) last saw the deceased alive on Feb. 17, 1961 , and that death occurred at 8 M, from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar, M. D.		22b. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Md.	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVA. (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Shey, Jr., Baltimore 30, Md.		25a. REC'D BY REGISTRAR FEB 20 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01557

1577

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>443 Range Road</u>		e. STREET ADDRESS <u>443 Range Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Lulu</u>	First <u>Lulu</u> Middle <u>Gerhold</u> Last <u>Gerhold</u>	4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1961</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-1887</u>
9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u>7</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Bookkeeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Office</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Charles H. Gerhold</u>	14. MOTHER'S MAIDEN NAME <u>Annie E. Kern</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT <u>Mrs. M.A. Gatton</u>	Address <u>Above</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSION CARIO-VASCULAR RENAL DISEASE</u> DUE TO (b) <u>no</u> DUE TO (c) <u>no</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): <u>CARCINOMA OF CAECUM - OPERATION SEPT 1960 - NO METASTASIS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> , 1960, to <u>FEB. 2</u> , 1961, that (I) (we) last saw the deceased alive on <u>JAN. 27, 1961</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Lloyd E. Saylor</u>	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>FEB. 3, 1961</u>
22c. PHYSICIAN'S NAME (Type) <u>LLOYDE SAYLOR</u>	22d. ADDRESS <u>3902 GREENMOUNT AVE - BALTO-18 MD.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-6-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u>		25a. REC'D BY REGISTRAR <u>FEB 7 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur J. K...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death).

VR A15 (4)
15M 9/60



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

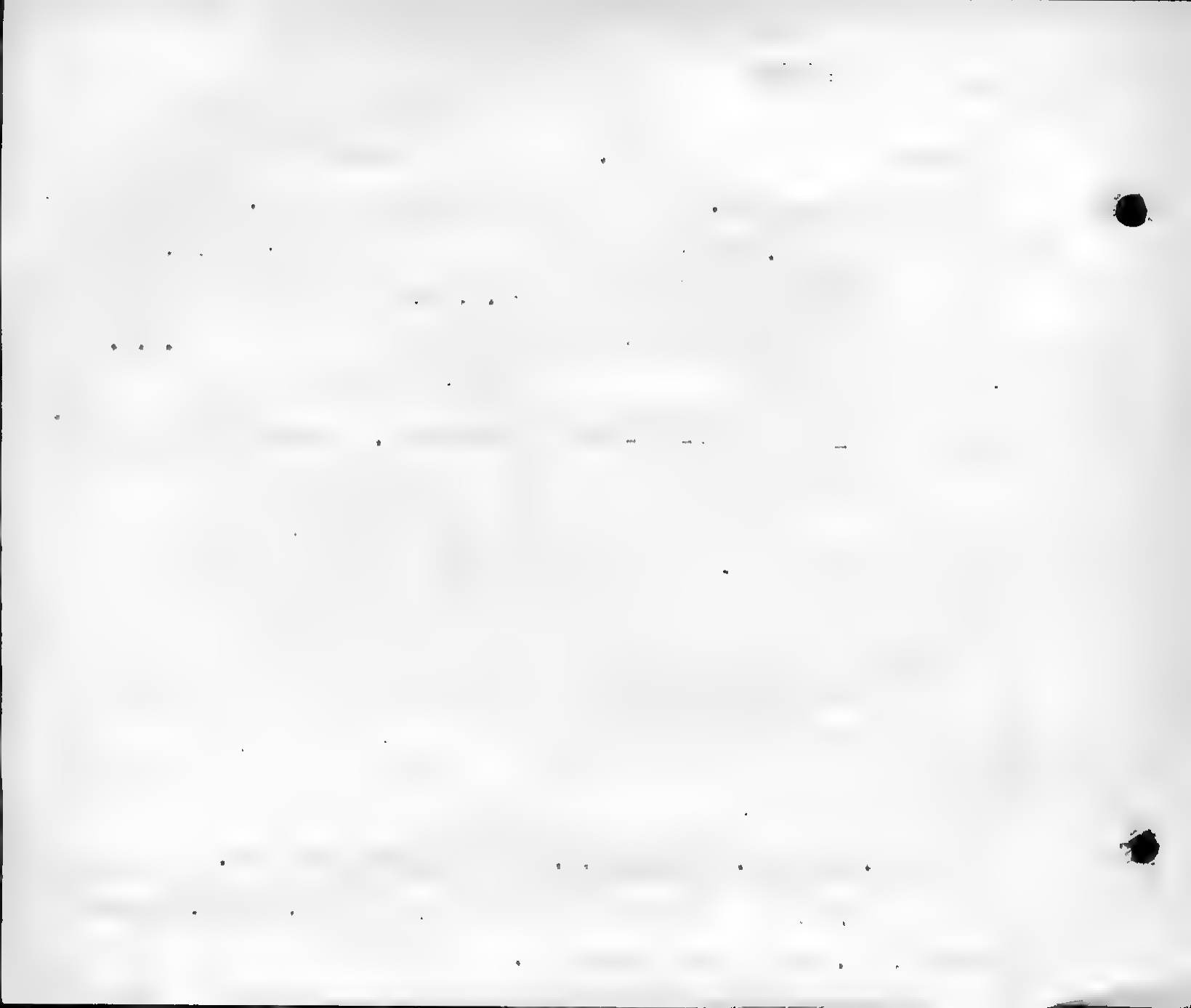
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01558

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 201 Hillendale Ave.		d. STREET ADDRESS /201 Hillendale Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marion A. Gobrecht		4. DATE OF DEATH February 18, 1961	
5 SEX Male		6 COLOR OR RACE White	
7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 9, 1914	
9. AGE (In years last birthday) 46 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam fitter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Gobrecht		14. MOTHER'S MAIDEN NAME Mollie Stayler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 11 213-075-5458	
17. INFORMANT Charlotte M. Gobrecht		Address 201 Hillendale Ave.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 197.1 IMMEDIATE CAUSE (a) Sarcoma with widespread metastases to left pleura & chest wall, involving 6th rib left DUE TO (b) Primary Site Not determined DUE TO (c) Primary Site Not determined		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from April 13 1960 to Feb 18 1961 , that (I) (we) lost saw the deceased alive on Feb. 18 1961 , and that death occurred at 6:05 P. from the causes and on the date stated above			
22a. SIGNATURE Dr. Arthur C. Rossberg M.D.		22b. DATE SIGNED 2/20/61	
22c. PHYSICIAN'S NAME (Type) Dr. Arthur C. Rossberg M.D.		22d. ADDRESS 2436 Washington Blvd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/21/61	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town, or county) (State) Dorsey, Howard, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ambrose, Inc. 1328 Sulphur Spring Rd.		25a. REC'D BY REGISTRAR FEB 21 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1579 01559											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 16 c. LENGTH OF STAY IN b 48 Days d. STREET ADDRESS 3406 Mondawmin Avenue							
3. NAME OF DECEASED (Type or print) BENJAMIN				4. DATE OF DEATH February 14 1961				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 9, 1889		9. AGE (in years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter				10b. KIND OF BUSINESS OR INDUSTRY Public Building				11. BIRTHPLACE (County & State, or foreign country) Talbot Co., Maryland			
13. FATHER'S NAME Henson Gross				14. MOTHER'S MAIDEN NAME Maggie MN: Unknown				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 218-09-4292				17. ADDRESS OF INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PURULENT AND CHRONIC PYELONEPHRITIS WITH (b) HYDRONEPHROSIS AND HYDRO-URETER (c) BENIGN PROSTATIC HYPERTROPHY WITH URINARY RETENTION ARTERIOSCLEROSIS OF THE HEART.				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Thrombosis of both iliac arteries. Amputation, both legs due to/											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 28 1960, to February 14 1961, that (I) (we) last saw the deceased alive on February 14 1961, and that death occurred at P.M., from the causes and on the date stated above.											
22a. SIGNATURE Thomas F. Crahan				22b. DATE 2/15/61				22c. PHYSICIAN'S NAME THOMAS F. CRAHAN, M.D.			
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 2/17/61				23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery				23d. LOCATION (City, town or county) Baltimore 28, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				25a. REC'D BY REGISTRAR DATE FEB 21 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



1580

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Middle River</u>		c. LENGTH OF STAY IN lb <u>5 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>301 A. Holly Dr. ONK Grove Apts.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SAMUEL AIONZA HANKE</u>		4. DATE OF DEATH <u>Feb</u> <u>26</u> <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 17, 1901</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>17</u> Hours <u>11</u> Min <u>00</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Foreman</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	
11c. BIRTHPLACE (State or foreign country) <u>Wheeling W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Philip HANKE</u>		14. MOTHER'S MAIDEN NAME <u>Lenore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213 07 6932</u>	
17. INFORMANT <u>Samuel A. HANKE #8 East Midland Zone 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular accident</u> DUE TO <u>200X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arterio-Sclerotic Cardio-Vascular disease</u> DUE TO <u>Diabetes Mellitus</u> (c) <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY: Hour <u>o. 12</u> p. m. <u>19</u>		20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>60</u> , to <u>Feb-26</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb 25</u> , 19 <u>61</u> , and that death occurred at <u>5A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Gardner</u> M.D.		DATE SIGNED <u>2/26/61</u>	
PHYSICIAN'S NAME (Type) <u>Baltimore Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-1-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Czech</u>		ADDRESS <u>1211 Chesace Ave. Zone 6</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 2 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page _____ may be received by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSE 2. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1581

01561

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN 1b <u>20 yrs 10 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1610 Carswell St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last <u>Betty Marie Hanson</u>		4. DATE OF DEATH Month Day Year <u>February 19 1961</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/6/30</u>		9. AGE (In years last birthday) <u>30</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Clarence Hanson</u>				14. MOTHER'S MAIDEN NAME <u>Rose May Sweeney</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>Rosewood Hospital Records, Owings Mills, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Acute glomerulonephritis</u> DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>21 hrs</u> <u>2 wks.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Congenital cerebral defect of undetermined cause, epilepsy, mental retardation, severe</u>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>									
21. I certify that <u> </u> (this hospital) attended the deceased from <u>4-7-1932</u> to <u>2-19-1961</u> , that <u> </u> (we) last saw the deceased alive on <u>2-19-1961</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.																			
22a. SIGNATURE <u>Edward J. Mathews</u>						22b. DATE SIGNED <u>2-19-61</u>		22c. PHYSICIAN'S NAME (Type) <u>Edward J. Mathews, M.D.</u>				22d. ADDRESS <u>Rosewood State Training School</u> <u>Owings Mills, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>2-22-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEAR HILL CEM</u>				23d. LOCATION (City, town or county) <u> </u> (State) <u> </u> <u>BALTO ANNE ARUNDEL CO MD</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. EVANS & SON</u>						25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>											

FEB 21 '61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1582

01562

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 1016 East Preston St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Harris Last Harris		4. DATE OF DEATH Month Feb. Day 19 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1900
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 60 Days 60 Hours 60 Min 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10b. KIND OF BUSINESS OR INDUSTRY tailoring establish. Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jeremiah Harris		14. MOTHER'S MAIDEN NAME Agnes Tice	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Respiratory Failure DUE TO (b) Carcinoma of The Lung DUE TO (c) lyng cause last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 30, 1961 to Feb. 19, 1961 , that (I) (we) last saw the deceased alive on Feb. 19, 1961 , and that death occurred at 6:28 M. from the causes and on the date stated above.			
22a. SIGNATURE Blanca G. Gimenez		22b. DATE SIGNED Feb. 19/61	
22c. PHYSICIAN'S NAME (Type) Blanca G. Gimenez		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATON, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-22-61	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Govans, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR FEB 21 '61	
		25b. REGISTRAR'S SIGNATURE Carlton S. Thomas	



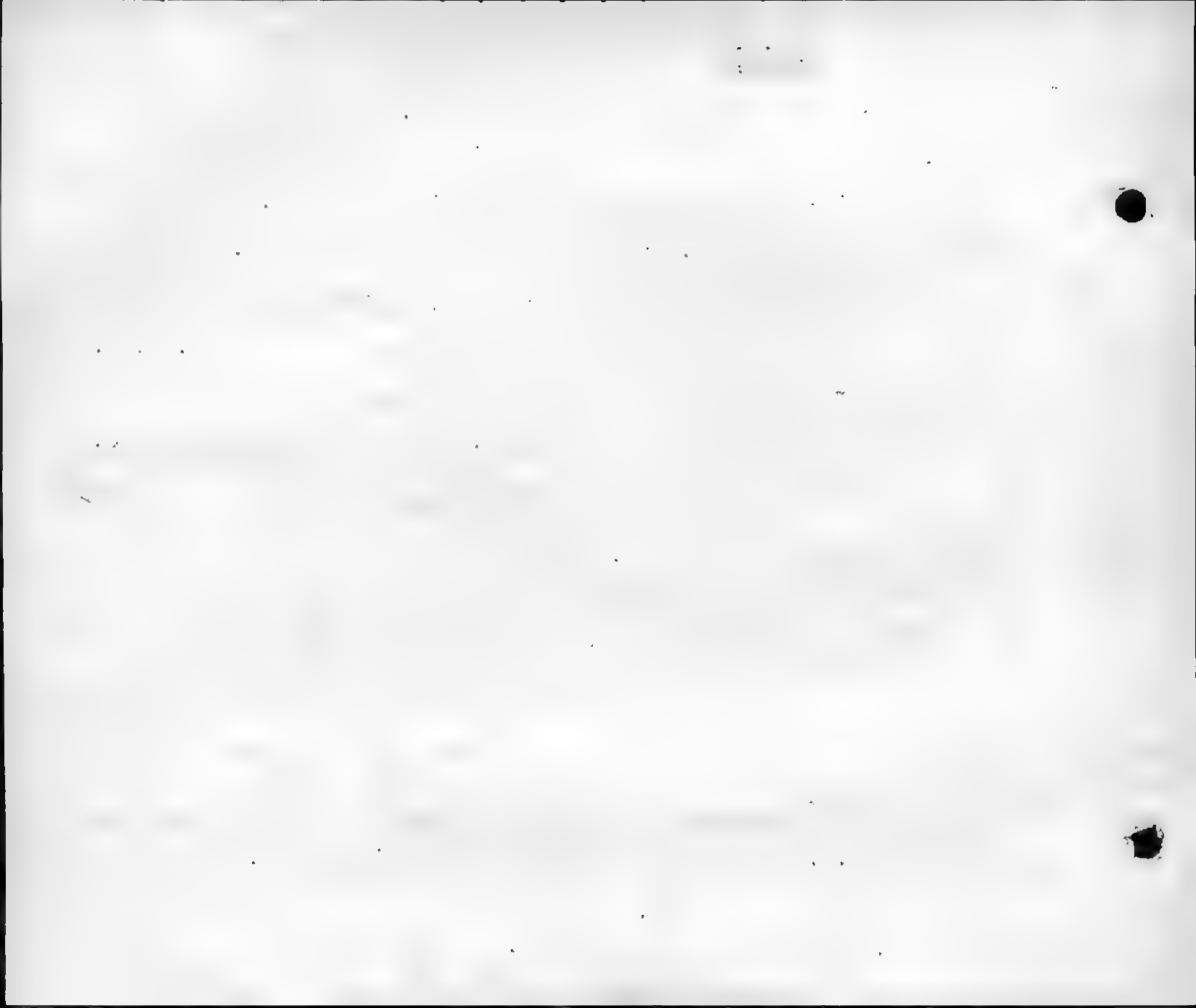
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1583 CERTIFICATE OF DEATH

01563

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a STATE Md. b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-Violetville		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3901 Coolidge Avenue		d. STREET ADDRESS 3901 Coolidge Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Myrtle E. Hartlove		4. DATE OF DEATH Month Day Year Feb. 23, 1961 19	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1895 9 AGE (in years last birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Harold Barnes	
14. MOTHER'S MAIDEN NAME Julia Barnett		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address John E. Hartlove 3901 Coolidge Ave. #29	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Arteriosclerosis (b) Hypertension DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Nephritis, Emphysema, Bronchitis			INTERVAL BETWEEN ONSET AND DEATH 11 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 1948 to Feb 1961 , that (I) (we) last saw the deceased alive on 15 Feb 1961 and that death occurred at 10 AM , from the causes and on the date stated above.			
22a. SIGNATURE H. H. Bayliss		22b. DATE SIGNED 24 Feb 61	
22c. PHYSICIAN'S NAME (Type) H. H. Bayliss		22d. ADDRESS 1600 Wilkens Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/27/61	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Ave.		25a. REC'D BY REGISTRAR FEB 27 '61	25b. REGISTRAR'S SIGNATURE Arthur L. Kraus



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1584

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01564

1. PLACE OF DEATH a. COUNTY <u>Towson</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Hospital</u>		d. STREET ADDRESS <u>1100 E. Baltimore St.</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas E. Wheeler</u>		4. DATE OF DEATH <u>April 11</u> 19 <u>61</u>	
5. SEX <u>CT</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 6, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>Thomas E. Wheeler</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Wheeler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT <u>Thomas E. Wheeler</u> Address <u>1100 E. Baltimore St.</u>	
16. SOCIAL SECURITY NO. <u>1-11-111111</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure - c lobar</u> DUE TO <u>pneumonia - sequelae - fractured hip</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Coronary insufficiency - c Angina.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19</u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>APRIL - 1, 1949</u> to <u>FEB 11, 1961</u> , that (I) (the) last saw the deceased alive on <u>FEB 11, 1961</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Thomas E. Wheeler</u>		22b. DATE SIGNED <u>APR 11 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>		22d. ADDRESS <u>Randallstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>Feb 11 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>FEB 17 '61</u>	



VS. A15ME
5M 7/59

01565

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>117 Rd</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>117 Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PARK Rd</u>		e. IS RESIDENCE ON A FARM? 1 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alfred Charles HAVENSTEIN</u>		4. DATE OF DEATH Month <u>Mar</u> , Day <u>27</u> , Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 11, 1896</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		9b. AGE (In years last birthday) <u>65</u> yrs.	
10a. KIND OF BUSINESS OR INDUSTRY <u>Dr. Bauer</u>		10b. PLACE OF BIRTH (State or foreign country) <u>Germany</u>	
11. FATHER'S NAME <u>Ernest Havenstein</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. MOTHER'S MAIDEN NAME <u>Anna Maria Havenstein</u>		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
15. SOCIAL SECURITY NO. <u>212-01-1241</u>		16. INFORMANT <u>Havenstein</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>120.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dr. M. Kieffer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. M. Kieffer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Mar 1 '61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 2, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lake View Memorial Park</u>		22d. LOCATION (City, town, or country) _____ (State) _____	
23. FUNERAL DIRECTOR <u>Fred. A. Cole</u>		24a. REC'D BY REG. STRAR <u>19134 Bultha St.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>		DATE <u>MAR 1 '61</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1586

CERTIFICATE OF DEATH

01564

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard
c. LENGTH OF STAY IN 1b 17 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point
d. STREET ADDRESS 912 "H" Street - 19
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last
CHARLES HEAD
4. DATE OF DEATH February 7 1961
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH Sept. 9, 1891
9. AGE (In years last birthday) 69 yrs IF UNDER 1 YEAR: Months 69 Days 69 Hours 69 Min. 69
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist 10b. KIND OF BUSINESS OR INDUSTRY Steel Industry 11. BIRTHPLACE (County & State, or foreign country) Johnstown, Penna. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Head 14. MOTHER'S MAIDEN NAME Margaret Morgan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-1 16. SOCIAL SECURITY NO. 213-07-2330 17. INFORMANT Clinical Records address VAH Baltimore 18, Md - FORT HOWARD DIVISION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ADVANCE EMPHYSEMA OF LUNGS WITH FIBROSIS AND ATELECTASIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) CHRONIC BRONCHITIS
(c) CARDIAC DECOMPENSATION & EDEMA OF LUNGS DUE TO (a) and (b)
INTERVAL BETWEEN ONSET AND DEATH 17 YEARS
UNKNOWN
20 DAYS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

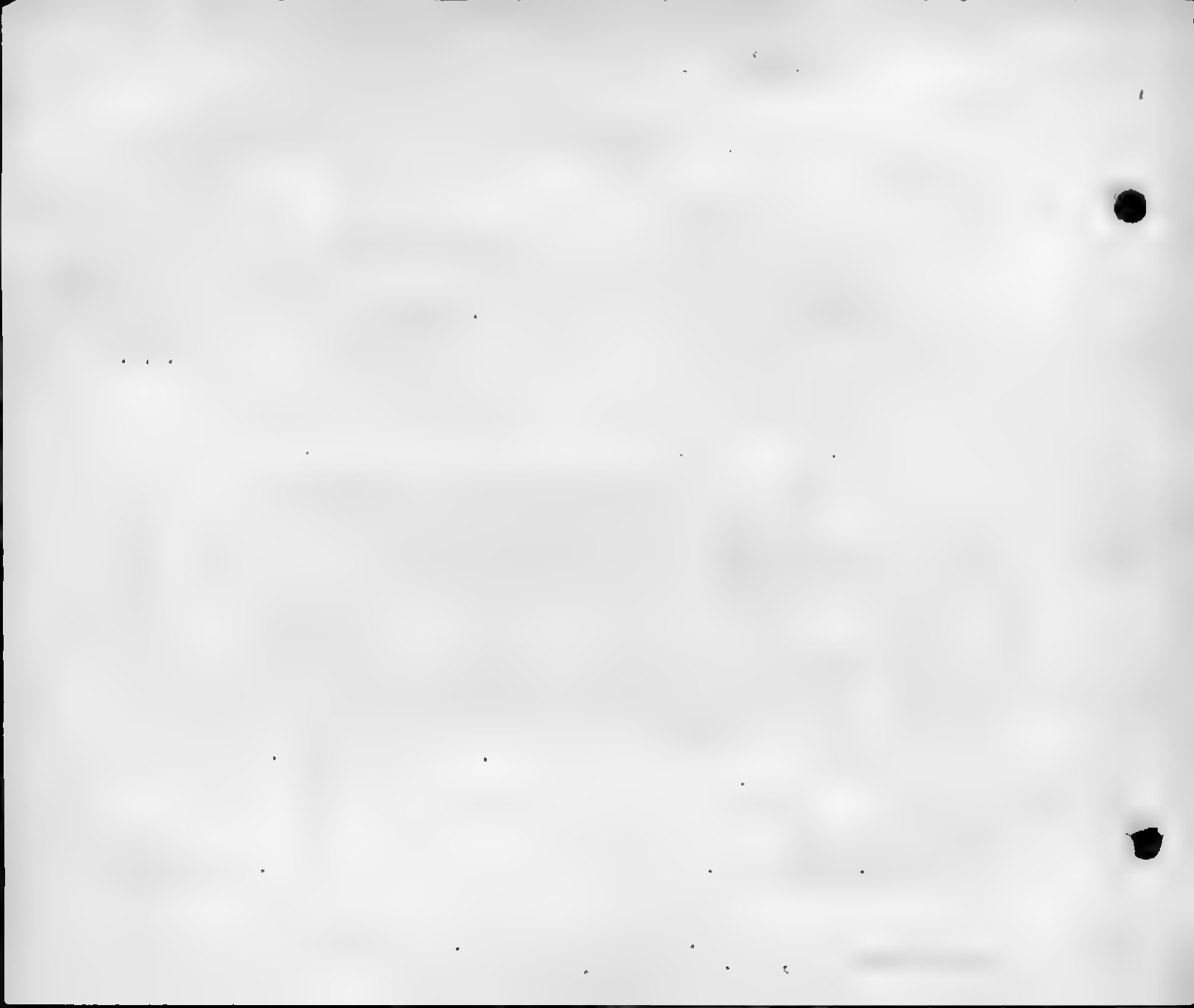
21. I certify that (X) (this hospital) attended the deceased from Jan. 21 1961 to Feb. 7 1961, that (X) (we) last saw the deceased alive on Feb. 7 1961, and that death occurred at P.M. from the causes and on the date stated above.

22a. SIGNATURE Thomas F. Crahan M.D. 22b. DATE SIGNED 2/8/61
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D. 22d. ADDRESS VAH, Baltimore 18, Maryland
VAH, Fort Howard, Md., Fort Howard Division

23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 2-10-61 23c. NAME OF CEMETERY OR CREMATORY Baltimore National 23d. LOCATION (City, town or county) (State) Baltimore Maryland

24. FUNERAL DIRECTOR'S SIGNATURE William Cook-Blight, Inc. ADDRESS St. Paul & Preston Sts. Baltimore, Maryland 25a. RECORDING REGISTRAR'S SIGNATURE Arthur L. Thomas 25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any information is necessary, the Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Int. Western State Hosp</u>					c. LENGTH OF STAY IN 1b <u>10 1/2 hrs.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Int. Western State Hosp</u>					e. STREET ADDRESS <u>4001 Thurgood St.</u>					
3. NAME OF DECEASED (Type or print) <u>WAKREN LOWELL</u>					f. DATE OF DEATH Last <u>HEAP</u> Month <u>Feb.</u> Day <u>8</u> Year <u>1961</u>					
5. SEX <u>Male</u>					6. COLOR OR RACE <u>White</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH <u>5-13-89</u>					
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS Month <u>5</u> Days <u>25</u> Hours <u></u> Min. <u></u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Certified Pilot</u>					11. BIRTHPLACE (State or foreign country) <u>Illinois</u>					
10b. KIND OF BUSINESS OR INDUSTRY					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>John H. Heap</u>					14. MOTHER'S MAIDEN NAME <u>Alta?</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO.					
17. INFORMANT <u>Int. Western State Hosp.</u>					Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Thb (Sept.)</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. (c) <u></u> DUE TO										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>None</u>										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>										
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>Sept.</u> 19 <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <u>None</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) <u>None</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>D.D. Caples</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>D.D. CAPLES</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/11/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>SUITLAND, MARYLAND</u>				
23. FUNERAL DIRECTOR <u>MARTIN W. HYSOING CO. 1300 N. ST. N.W. - WASH. D.C.</u>						24a. REC'D BY REGISTRAR DATE <u>FEB 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>		

DATE SIGNED
2-8-61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1588

01568

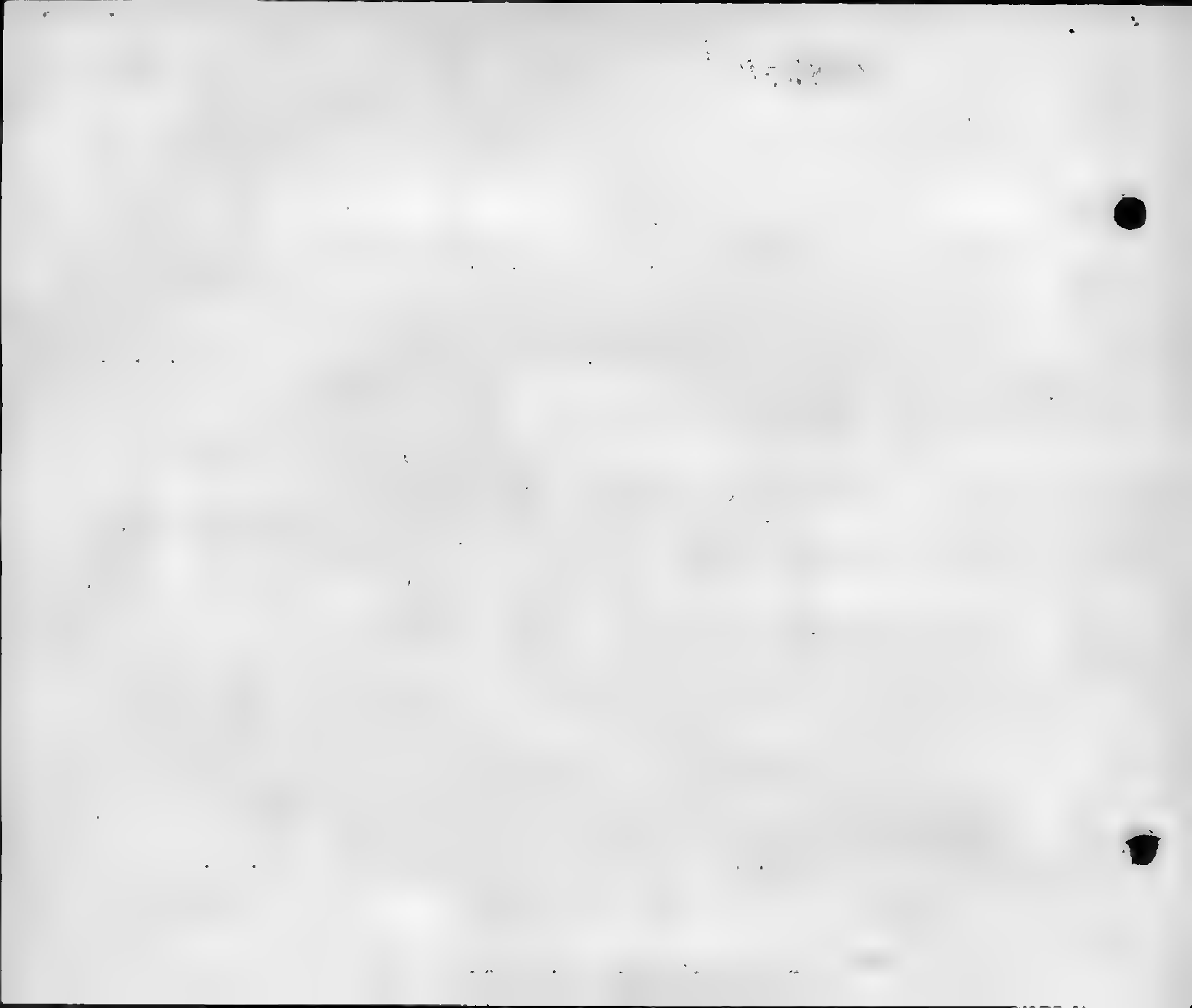
1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson- Anneslie	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Towson Conv. Home		d. STREET ADDRESS 6807 York Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Meta Middle C. Last Heim		4. DATE OF DEATH Month Feb. Day 11 Year 19 61	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1887
9 AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Companion		10b. KIND OF BUSINESS OR INDUSTRY Berlin, Germany	
11 BIRTHPLACE (State or foreign country) Berlin, Germany		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Otto Schmiediek		14. MOTHER'S MAIDEN NAME Martha Vitchdok	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-34-2108	
17. INFORMANT Mrs. Margaret Chamberlain-		Address 701 Murdock Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 260X DUE TO Decompensating Cardio Vascular System Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) Ischemic M.I.		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from June 1, 1959 to Feb 11, 1961. that (I) (we) last saw the deceased alive on Feb 11, 1961, and that death occurred at 4 P.M. from the causes and on the date stated above			
22a. SIGNATURE Laurence C. Post		22b. DATE SIGNED 2/13/61	
22c. PHYSICIAN'S NAME (Type) LAURENCE C. Post		22d. ADDRESS 6805 York Rd. Baltimore 12 Md	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-14-61	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City town or county) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Wm. J. Ickauer & Sons		25a. REC'D BY REGISTRAR DATE	
ADDRESS Baltimore 17, Md.		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1589
1589
01569

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN b <u>4 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 25</u> d. STREET ADDRESS <u>401 Bon Air Road</u>															
3. NAME OF DECEASED (Type or print) First <u>LEE</u> Middle <u>P.</u> Last <u>HEISER</u>				4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1961</u>															
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1890</u>													
9. AGE (in years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>				11. BIRTHPLACE County & State, or foreign country <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Daniel S. Heiser</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Cawell</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give word or dates of service) <u>Yes WW I</u>				16. SOCIAL SECURITY NO. <u>WW I</u>				17. INFORMANT <u>Clin. Rec. VAH, Baltimore 18, Md., Ft. Howard Div.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA RIGHT LOWER LOBE</u> <u>490X</u> <u>XXXXX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>XXXXX</u> (b) <u>CALCIFICATION OF MITRAL VALVE WITH STENOSIS & INSUFFICIENCY</u> (c) <u>CARDIAC DECOMPENSATION DUE TO (b)</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4+ Days</u> <u>UNKNOWN</u> <u>4 Days</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Edema of Lungs-recent. Generalized Arteriosclerosis, old.</u>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town, (County) (State)							
21. I certify that (X) (this hospital) attended the deceased from <u>February 6, 1961</u> to <u>February 10, 1961</u> , that (X) (we) last saw the deceased alive on <u>February 10, 1961</u> , and that death occurred at <u>12:45</u> M., from the causes and on the date stated above.																			
22a. SIGNATURE <u>Thomas F. Crahan</u> 22c. PHYSICIAN'S NAME (Type or print) <u>THOMAS F. CRAHAN, M.D.</u>																22b. DATE SIGNED <u>2/10/61</u>			
22d. ADDRESS <u>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-14-61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Anne Arundel County Maryland</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home, 237 Patapsco Ave., Balto. 25</u>				ADDRESS				25a. REC'D BY REGISTRAR <u>DATE FEB 14 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Catherine F. Krahn</u>							



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1590

01560

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Dundalk</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1909 DUNDALK AVE.</u>				d. STREET ADDRESS <u>11909 DUNDALK AVE</u>			
3. NAME OF DECEASED (Type or print) <u>CLARENCE E HICKS</u>				4. DATE OF DEATH <u>FEBRUARY 24, 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCTOBER 27, 1904</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRIAL</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>HENRY HICKS</u>			
14. MOTHER'S MAIDEN NAME <u>ESTELLE</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>216-03-5806</u>				17. INFORMANT <u>ELIZABETH HICKS</u> Address <u>1909 DUNDALK AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> 4.)) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-1</u> 19 <u>55</u> to <u>2-24</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2-24</u> 19 <u>61</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>George L. Schuyab</u>				22b. DATE SIGNED <u>2-24-61</u>			
22c. PHYSICIAN'S NAME (Type) _____				22d. ADDRESS <u>2 K. V. Shop Balt 2</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-27-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>		23d. LOCATION (City, town, or county) (State) <u>WOODLAWN, MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE L. SCHUYAB</u> ADDRESS <u>Funeral Home Francis W. Miller 2101 Frederick Ave. Balt.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 28 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	



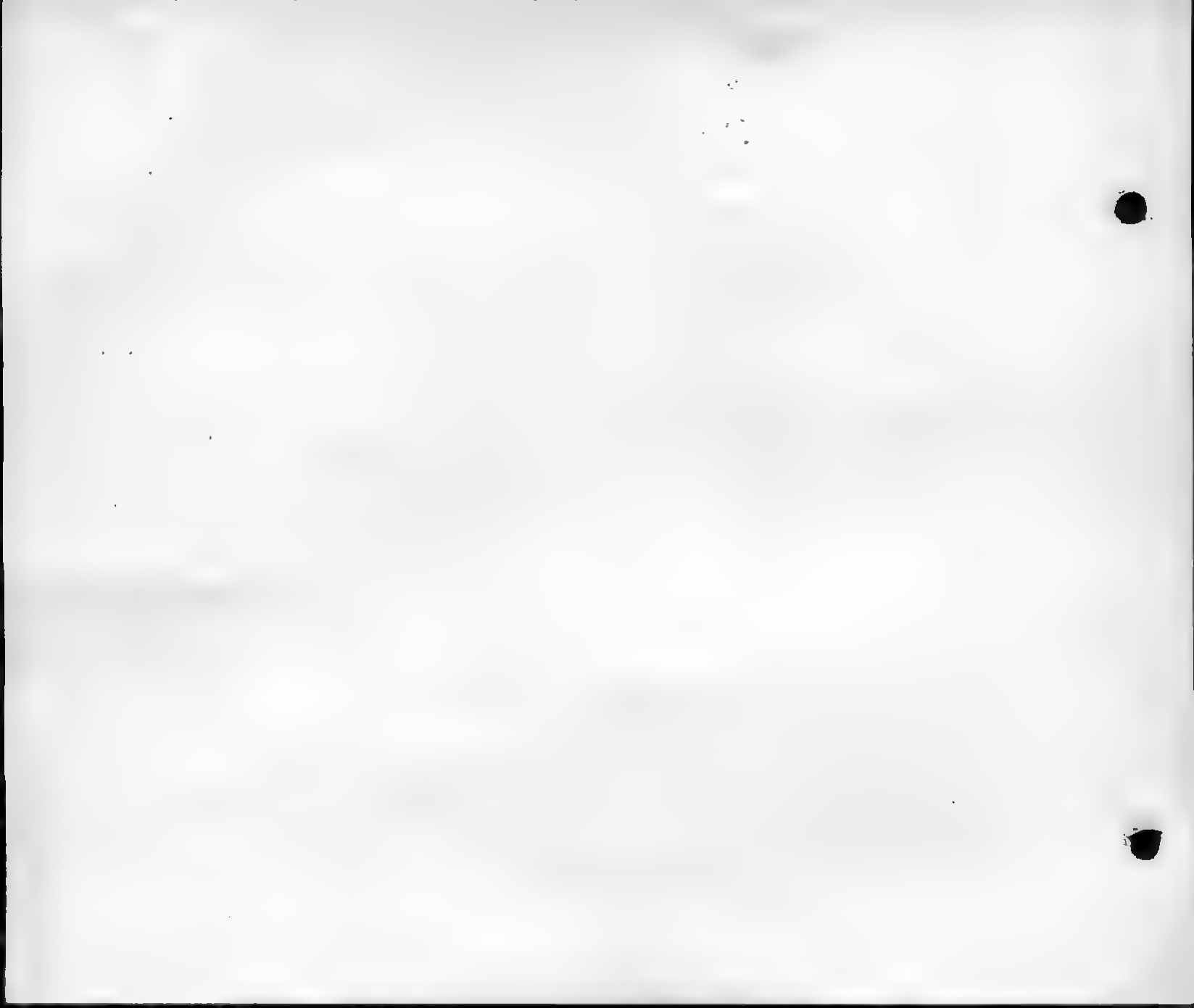
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician to the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
1591
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01571

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived) (If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. LENGTH OF STAY IN 1b 36yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2058 York Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	
3. NAME OF DECEASED (Type or print) First Nellie Middle Pitts Last Hines		4. DATE OF DEATH Month 2-9-61 Day 19 Year 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-1882
9. AGE (In years last birthday) 78 yrs.		10. F UNDER 1 YEAR Months Days 11. F UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ???Hines		14. MOTHER'S MAIDEN NAME Sarah ?????	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT George A. Hines,		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CEREBRO-VASCULAR DISEASE DUE TO (c) 6 YRS		INTERVAL BETWEEN ONSET AND DEATH 5 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1956 to FEB 9 , 1961, that (I) (we) last saw the deceased alive on FEB 9 , 1961, and that death occurred at 4:45 P.M. from the causes and on the date stated above			
22a. SIGNATURE William A. Pillsbury		22b. DATE SIGNED 2-10-61	
22c. PHYSICIAN'S NAME (Type) WILLIAM A. PILLSBURY		22d. ADDRESS TIMONIUM, MD.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 2-13-61	
23c. NAME OF CEMETERY OR CREMATORY Jessop Methodist		23d. LOCATION (City, town, or county) (State) Sparks, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		25a. REC'D BY REGISTRAR DATE FEB 14 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Haines			



may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

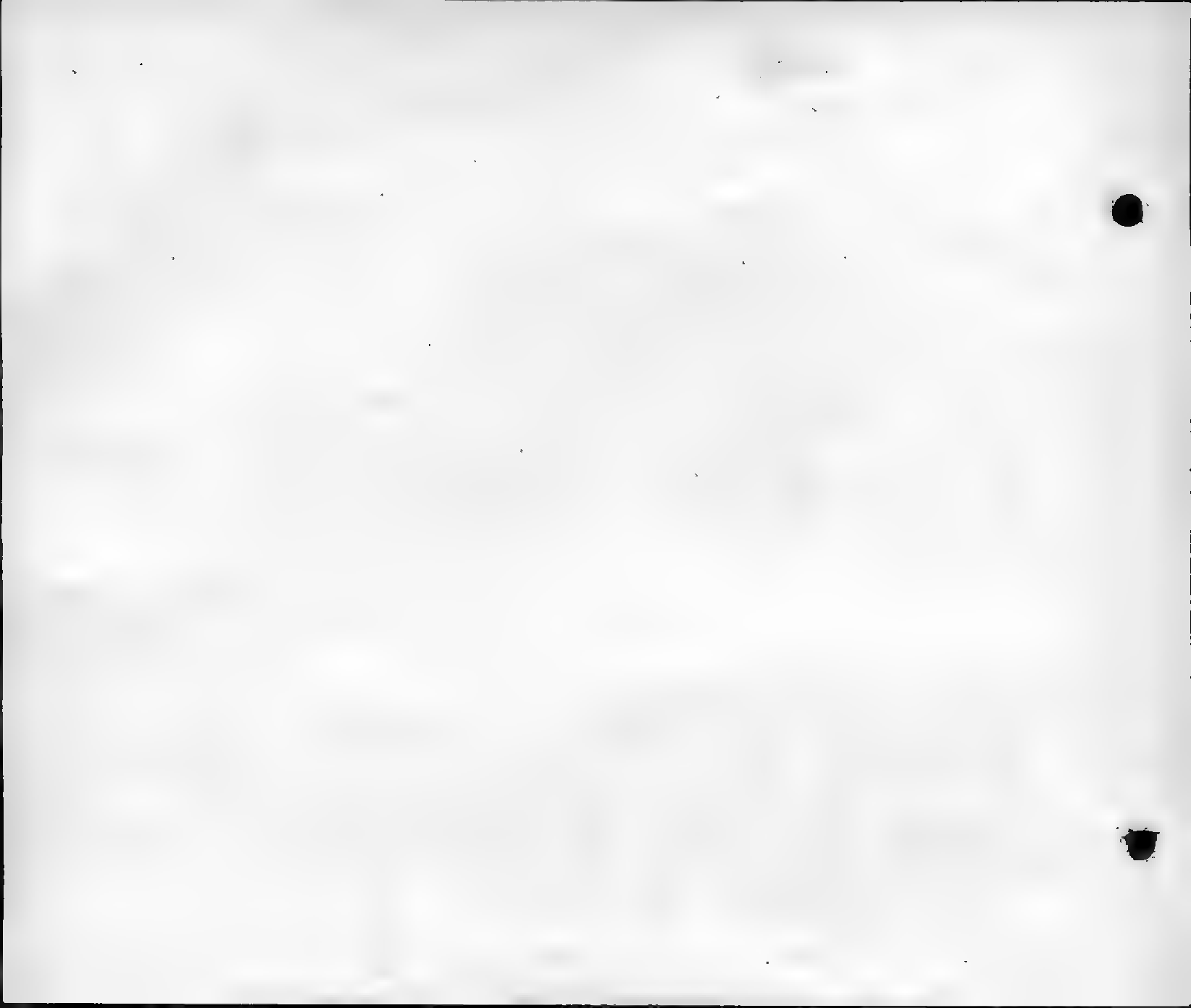
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1592

CERTIFICATE OF DEATH

01572

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3501 Midfield Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) MOLLIE K. HOFFBERGER		4. DATE OF DEATH Thurs Feb 9, 1961	
5 SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March- 1884
9 AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR: Months 76 Days 76 Hours 76 Min 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman Krieger		14. MOTHER'S MAIDEN NAME Bettye Beck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Mrs. Esther Rosenbloom- 3501 Midfield Road	
17. INFORMANT Mrs. Esther Rosenbloom- 3501 Midfield Road		Address Mrs. Esther Rosenbloom- 3501 Midfield Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 arrows of the colon DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Sept 1960	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Nov 26, 1953 to Feb 7, 1961 , that (I) (we) last saw the deceased alive on Feb 7, 1961 , and that death occurred at 39 M. from the causes and on the date stated above			
22a. SIGNATURE Samuel Whitehouse		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) SAMUEL WHITEHOUSE		22d. ADDRESS 2933 N. W. St Baltimore Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 10, 1961	
23c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc. 6010 Reist Road		25a. REC'D BY REGISTRAR FEB 14 '61 25b. REGISTER SIGNATURE Arthur L. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1593

CERTIFICATE OF DEATH

Reg. Dist. **01578**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7625 Liberty Road		d. STREET ADDRESS 7625 Liberty Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle R. Last HOLZAPFEL		4. DATE OF DEATH Month February Day 3 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1875
9. AGE (In years last birthday) 85 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin Rhode		14. MOTHER'S MAIDEN NAME Margaret Schuster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 		16. SOCIAL SECURITY NO. None	
INFORMANT Address Carl M. Holzapfel-7625 Liberty Road - 7			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 153.9 DUE TO Terminal Metastatic Carcinoma, intestinal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arteriosclerotic Cardiovascular disease, primary (b) (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 23 , 1961, to Feb 3 , 1961, that I last saw the deceased alive on Feb 2 , 1961, and that death occurred at 4:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John J. Farrell		ADDRESS (Street, city or town, state) 9017 Liberty Rd Randallstown, Md	
PHYSICIAN'S NAME (Type) Ellsworth Armacost		DATE FEB 7 '61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/6/1961	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		24b. REGISTRAR'S SIGNATURE C. J. L. Kline	

Ellsworth Armacost-4600 Liberty Hghts. Ave.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No. 01574

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN lb <u>6mth15dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>William</u> Last <u>Hopkins, Sr.</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1887</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>special police officer A, A Co. Md</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>unknown Elizabeth Roland Hopkins</u>		14. MOTHER'S MAIDEN NAME <u>unknown Margaret Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO <u>220-07-3850</u>	
17. INFORMANT <u>Jos. William Hopkins (2)</u>		18. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost (b) <u> </u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome assoc. with Arteriosclerosis, Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>July 27</u> , 19 <u>60</u> , to <u>Feb 5</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb 5</u> , 19 <u>61</u> , and that death occurred at <u>6</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jose R. Arizaga</u>		DATE SIGNED <u>SPRING GROVE STATE HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>Jose R. Arizaga, M.D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Feb 8 - 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. M. Taylor</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 7 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

VS A15 (4)
15E 10/57



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1595

CERTIFICATE OF DEATH

01575

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Essex</u> c. LENGTH OF STAY (in 1b) <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>517 Virginia Ave.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Essex, Balto. 21</u> d. STREET ADDRESS <u>1517 Virginia Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DOROTHY M HORNER</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>5</u> Year <u>1961</u>		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u>			
7. MARIED <input type="checkbox"/> NEVER MARIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 13, 1890</u>		9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Peterson</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Brown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u> </u> Address <u> </u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 410.1 DUE TO <u>Coronary artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arterio-sclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fluoroxiconia</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>sudden death</u> <u>2 yr</u> <u>2 yr</u>			
20. TIME OF INJURY Month <u>Feb</u> Day <u>18</u> Year <u>1961</u> Hour <u> </u> a.m. <u> </u> p.m.							
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>							
20e. (City or town) <u>BALTO.</u> (County) <u>MD.</u> (State) <u>MD.</u>							
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 18, 1961</u> to <u>Feb 5, 1961</u> that (I) (we) last saw the deceased alive on <u>Feb 1, 1961</u> and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Miceli</u> 22b. DATE SIGNED <u>2/5/61</u>							
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D.</u> 22d. ADDRESS <u>108 S. TAYLOR AVE BALTO. 21 MD</u>							
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-8-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BALTO. CEMETERY</u>			
23d. LOCATION (City, town or county) <u>BALTO.</u>		23e. (State) <u>MD.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>			
24a. ADDRESS <u>418 Eastern Blvd.</u>		25a. RECEIVED BY REGISTRAR <u>FEB 8 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



may be recorded by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1596

CERTIFICATE OF DEATH

01576

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
c. LENGTH OF STAY IN 1b Oct. 10, 60				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO, MD.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home				d. STREET ADDRESS 329 Harlem Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle May Last Hube				4. DATE OF DEATH Month Feb. Day 16 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1892	
9. AGE (In years lost birthday) 69 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Raymond Shenton				14. MOTHER'S MAIDEN NAME Coara Gillingham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Hypostatic Belated 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CVA multiple small DUE TO (c) Arteriosclerosis generalized							
INTERVAL BETWEEN ONSET AND DEATH 3 Days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 10, 1960 to Feb 16, 1961 , that (I) (we) last saw the deceased alive on 2/16, 1961 , and that death occurred at 12 PM , from the causes and on the date stated above.							
22a. SIGNATURE Cliff Ratliff, Sr.				M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 3/17/61	
22c. PHYSICIAN'S NAME (Type) CLIFF RATLIFF, SR.				22d. ADDRESS 4605 EDMONDSON AVE #29			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
B		2-20-61		Clen Norton Cem		Clen Barnes Md	
24. FUNERAL DIRECTOR'S SIGNATURE Mc Cully Funeral Homes				ADDRESS 130 E. Fort St		25a. REC'D BY REGISTRAR DATE FEB 23 '61	
				25b. REGISTRAR'S SIGNATURE Quilley L. Kins			

I

MEDICAL CERTIFICATION



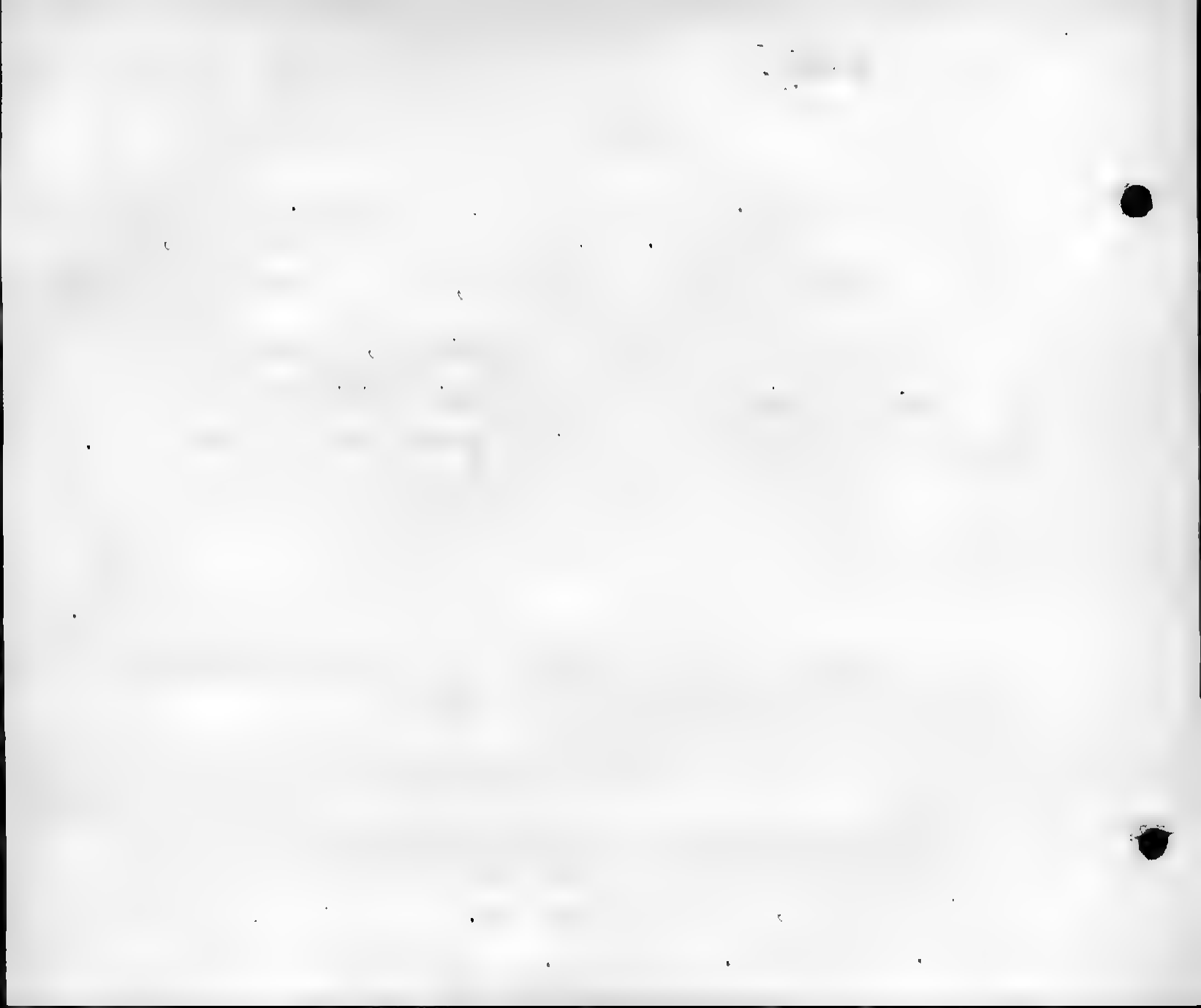
may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1597

01577

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3153 Baybriar Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Susanna</u> Middle <u>T.</u> Last <u>Isaacs</u>		4. DATE OF DEATH Month <u>February</u> Day <u>11</u> , Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1908</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Wehrheim</u>		14. MOTHER'S MAIDEN NAME <u>Jennie McGinity</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Edgar Howard Isaacs</u>		Address <u>3153 Baybriar Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>24</u> IMMEDIATE CAUSE (a) <u>CELLULITIS OF RT. ABDOMEN & TRUNK</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>OBESITY</u> DUE TO (c) <u>BRONCHIAL ASTHMA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 MO.</u> <u>YRS</u> <u>YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 19 50</u> to <u>Feb 11</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 19 61</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Stephen P. Mackowiak</u>		22b. DATE SIGNED <u>2-13-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN P. MACKOWIAK</u>		22d. ADDRESS <u>6714 HOLLA BIRD AV</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 14, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemt.</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>		25a. REC'D BY REGISTRAR <u>3000 E. Baltimore St.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		DATE <u>FEB 14 '61</u>	



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

APPROVED BY DR. D.D. CAPLES TE 3-2792

I

MARYLAND STATE DEPARTMENT OF HEALTH

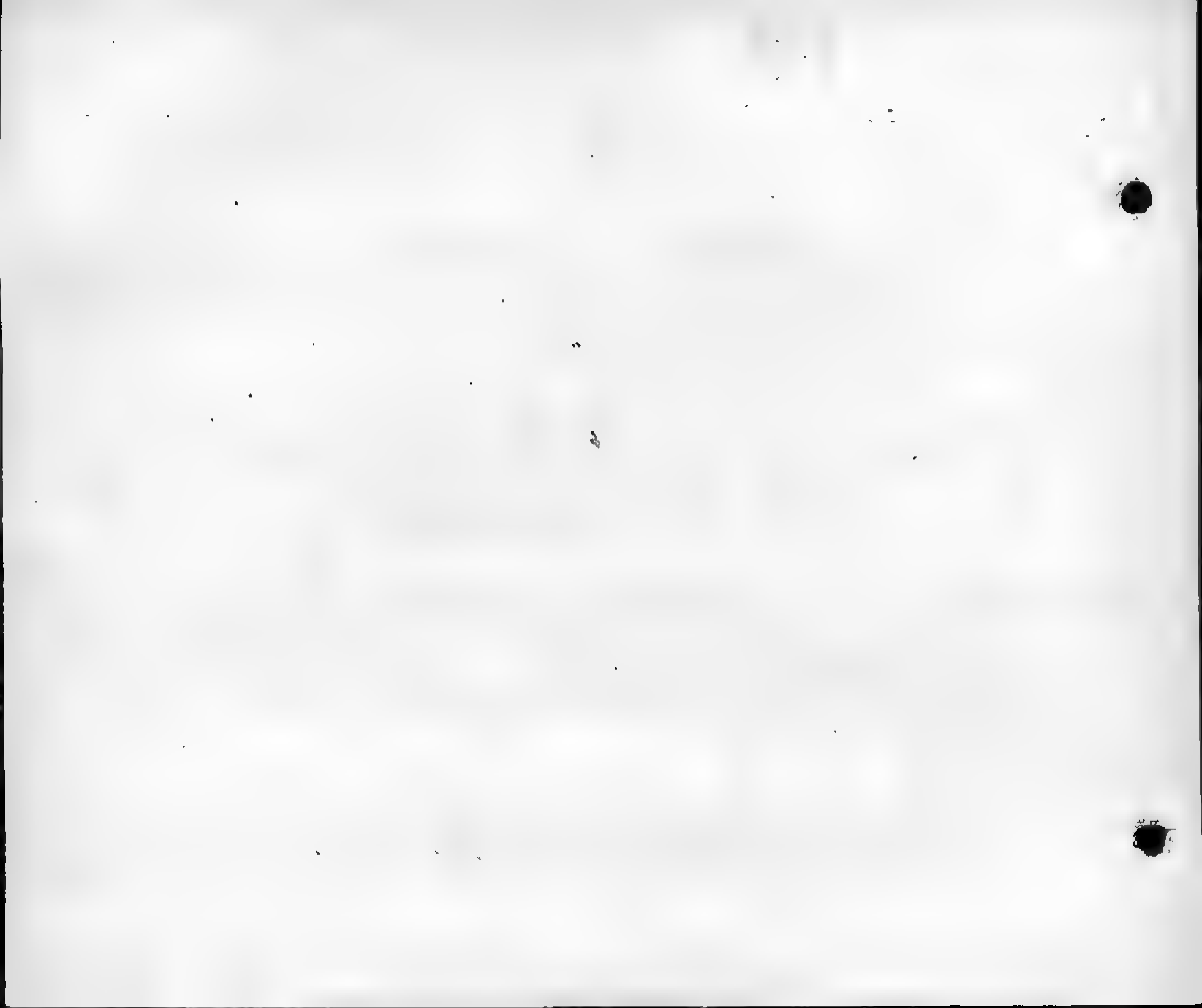
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1598

CERTIFICATE OF DEATH

01578

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission, a. STATE MARYLAND b. COUNTY BALTO. - CITY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WOODLAWN		c. LENGTH OF STAY IN 1b 2 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6608 TALLULAH AVE - 7				d. STREET ADDRESS 1 709 LIGHT ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First CATHERINE Middle JACKSON Last JACKSON				4 DATE OF DEATH Month 2 Day 15 Year 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 7, 1877	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY MORRIS				14. MOTHER'S MAIDEN NAME CATHERINE WAGNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 215073596		17. INFORMANT Address 6608 TALLULAH AVE BALTO. MD SISTER - MRS. GALLMEYER			
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 703.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FRACTURED HIP - LEFT DUE TO (c) 7 DAYS INTERVAL BETWEEN ONSET AND DEATH 7 DAYS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAM NER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) SLIPPED AND FELL ON KITCHEN FLOOR AT HOME					
20c. TIME OF INJURY Month, Day, Year 7:30 p.m. 2/8 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) BALTO. 7, BALTO. MD	
21. I certify that (I) (this hospital) attended the deceased from 2/8 1961 to 2/13 1961 , that (I) (we) last saw the deceased alive on 2/14 1961 , and that death occurred 2/13 1961 PM, from the causes and on the date stated above.							
22a. SIGNATURE Edwin L. Pierpont				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D.				22d. ADDRESS 8204 LIBERTY RD. - BALTO 7, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/20/61		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE		23d. LOCATION (City, town or county) (State) BALTO. MD	
24. FUNERAL DIRECTOR'S SIGNATURE J.T. STANSBURY				ADDRESS 6411 WINDSOR MILL RD		25a. REC'D BY REGISTRAR DATE FEB 17 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Fries			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

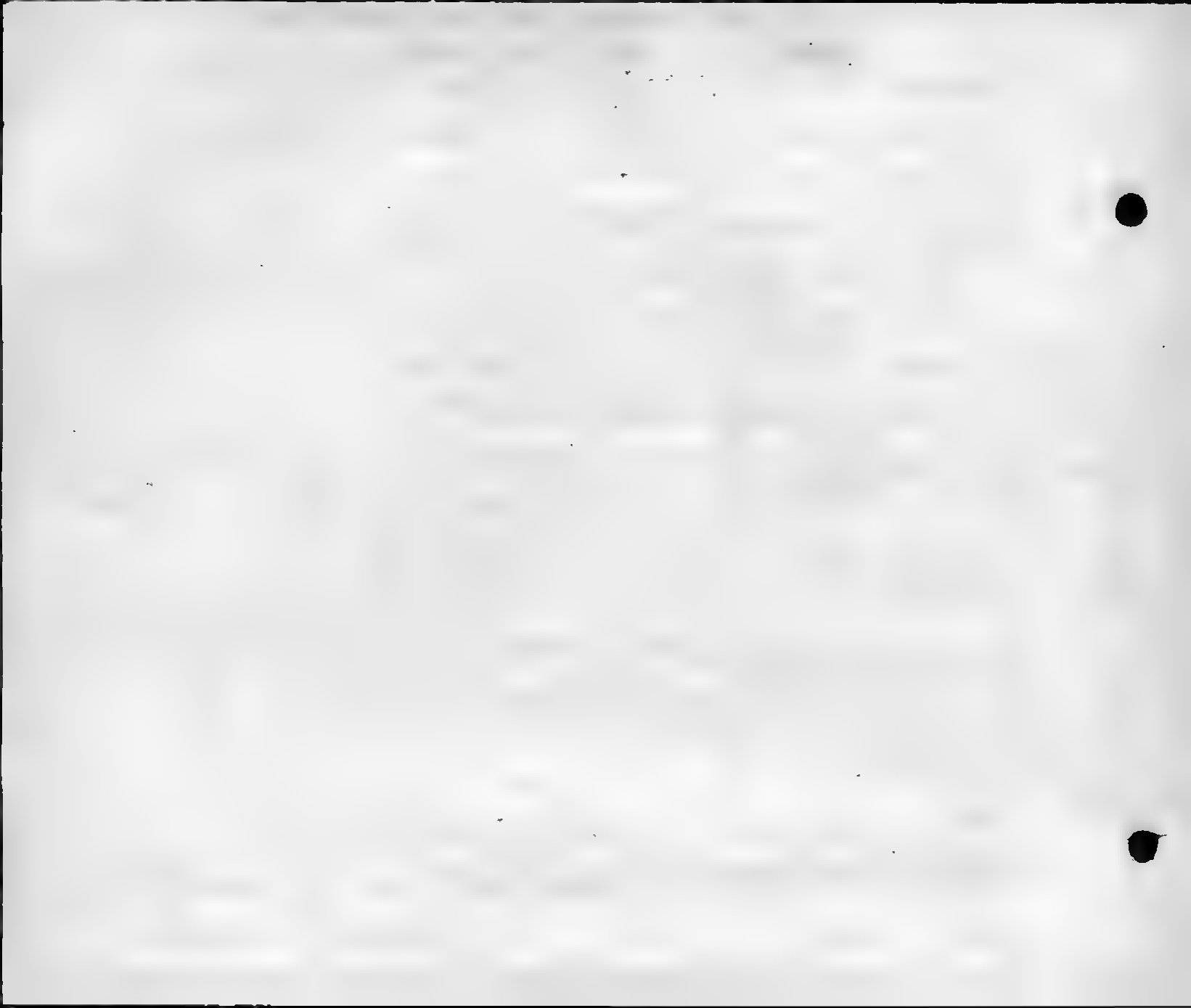
1599

CERTIFICATE OF DEATH

Reg. Dist. No.

01579

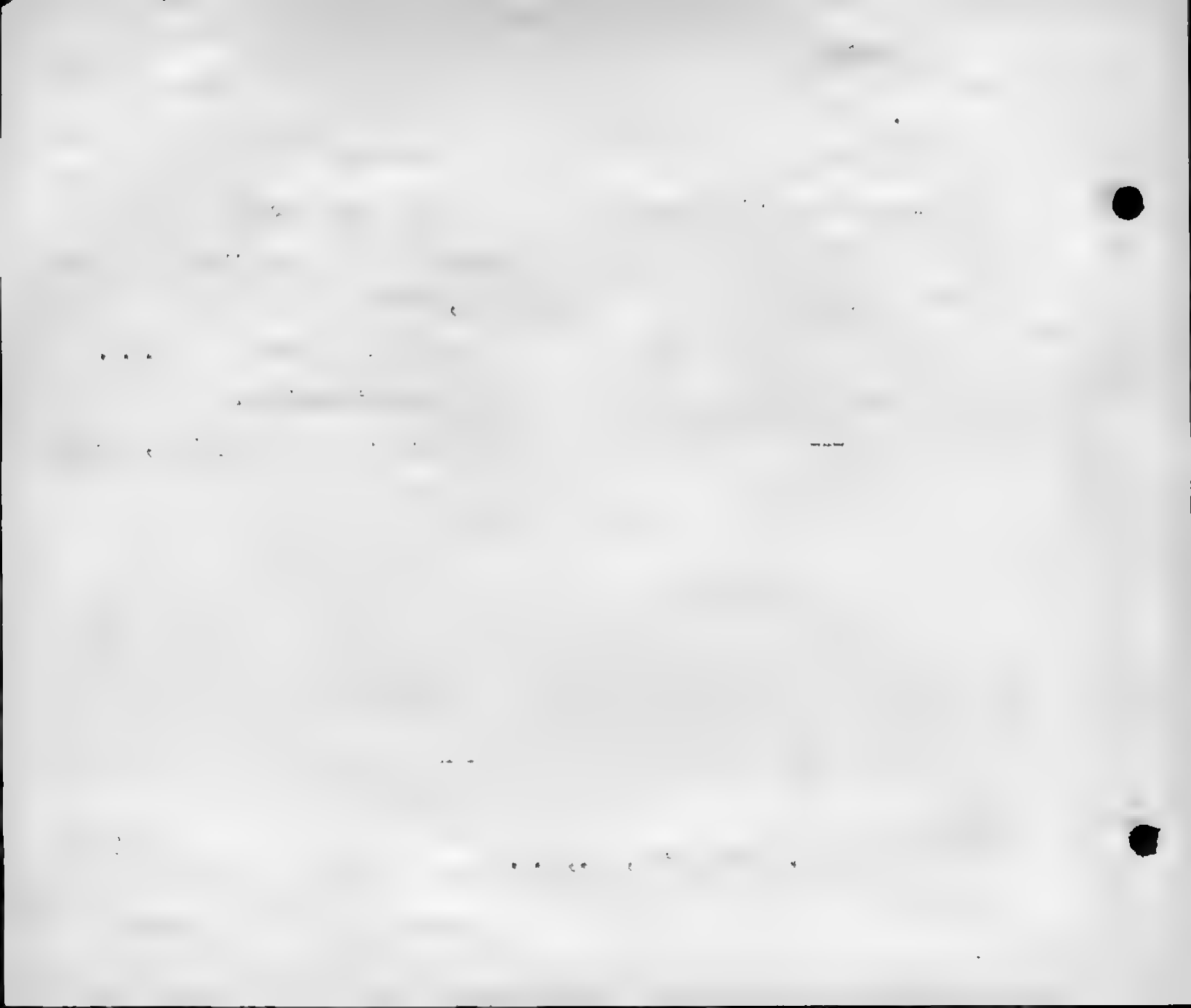
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>X</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>JUV HALL Nursing Home</u>				e. STREET ADDRESS <u>3040 THIRD AVE 1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELVA MAY JACKSON</u>				4. DATE OF DEATH Month Day Year <u>FEB. 21 1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 24-1898</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>ALEXANDER</u>				14. MOTHER'S MAIDEN NAME <u>EMMA DILLINGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Address <u>Joseph L. Jackson, Jr. 3040 Third Ave (Parkville)</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic carcinoma brain</u> DUE TO <u>Carcinoma Breast</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>1 year</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 20</u> , 19 <u>61</u> , to <u>Feb 21</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb 21</u> , 19 <u>61</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis Semenovoff</u>				ADDRESS (Street, city or town, state) <u>2108 CREMS RD</u>		DATE SIGNED <u>2/21/61</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOFF</u>				Baltimore, <u>20</u> Md			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>CREMATION</u>		<u>2-25-61</u>		<u>MORELAND PARK</u>		<u>BALTIMORE, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard Stick</u>				ADDRESS <u>5305 Hayford</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 23 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>	



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or the designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1600 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
01580											
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN It d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2702 Baker Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) GLENWOOD First Middle Last 4. DATE OF DEATH JAMES February 17 1961 Month Day Year						5. SEX Male 6. COLOR OR RACE Colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH April 28, 1947 9. AGE (in years last birthday) 13 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.						13. FATHER'S NAME Leroy James 14. MOTHER'S MAIDEN NAME Aileen Doris Robinson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO. None 17. INFORMANT Rosewood records Address Owings, Mills, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute laryngitis and acute bronchitis with early bronchopneumonia 474 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month. Day. Year. Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2/17/61 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D. Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2/20/61 22c. NAME OF CEMETERY OR CREMATORY no Auburn 22d. LOCATION (City, town, or country) (State) Baltimore											
23. FUNERAL DIRECTOR Manhattan P. Hayes ADDRESS 638 N. Gilman St. 24a. REC'D BY REGISTRAR FEB 27 '61 DATE 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus											



FOR STATE
HEALTH DEPT

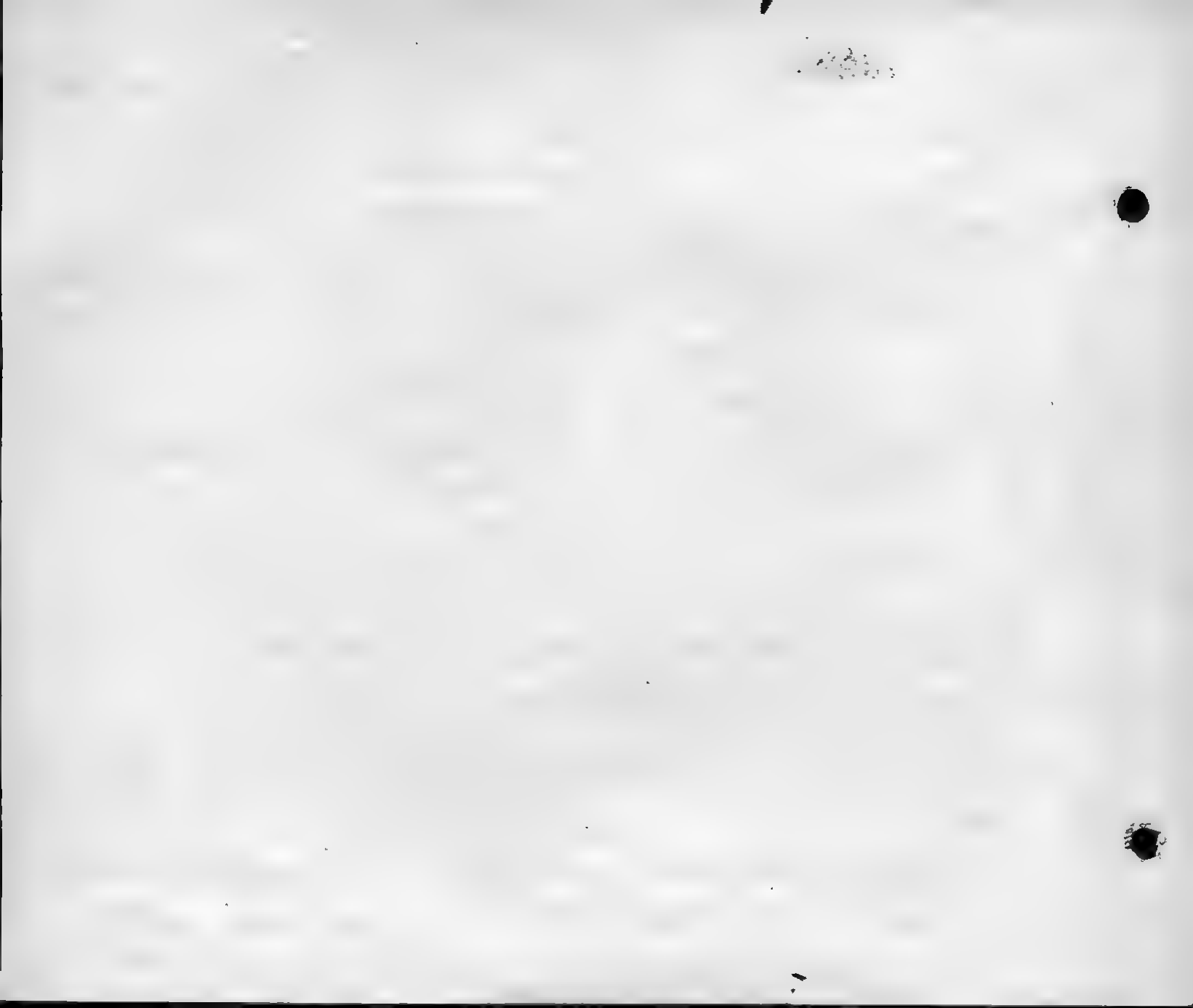
TO BE COMPLETED BY THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1601 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			
c. LENGTH OF STAY IN TB				d. STREET ADDRESS 2510 Yorkway			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2510 Yorkway				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Wilhelmina Jensen		First Middle Last		4. DATE OF DEATH Feb 16 19 61		Month Day Year	
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 22 1889	
9. AGE (In years last birthday) 71 yrs		10. FLUNDER: YEAR Months Days		11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Don't know				14. MOTHER'S MAIDEN NAME Don't know			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT Mrs Edith Davis Box 52 Route L Havre De Grace		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) B-S-C-L DISEASE DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Melvin B Davis M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASS. STANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) 6800 Mornington Road			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Feb 20/61		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co	
23. FUNERAL DIRECTOR Ullrich Funeral Home 2112 Dundalk Ave				24. REC'D BY REGISTRAR FEB 23 '61			
				25. REGISTRAR'S SIGNATURE Charles E. Knecht			

VS. A15ME
5M 7/59



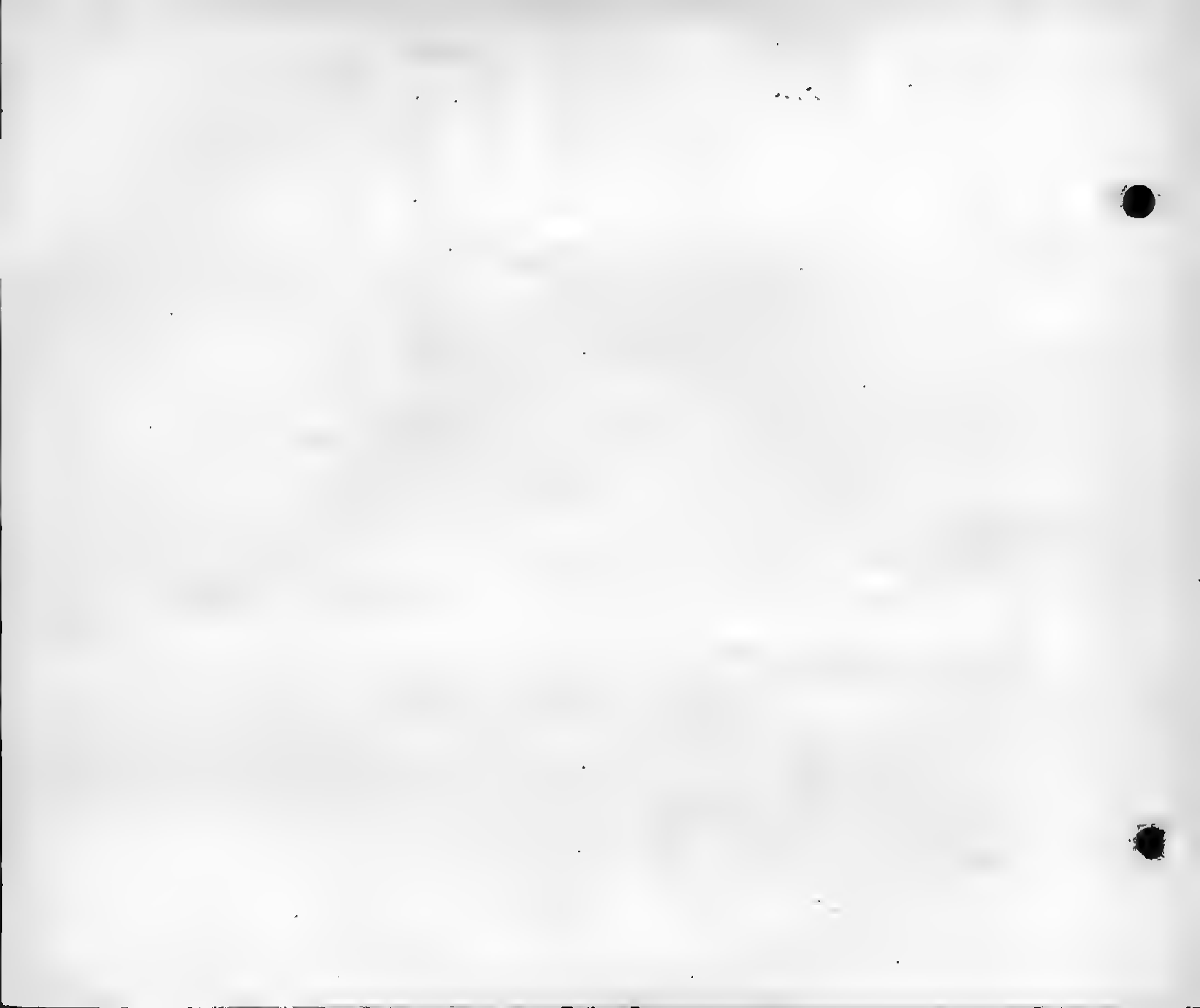
1 1602 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01582

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 33</u>		c. LENGTH OF STAY IN 1b <u>34</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>222 Center Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eloine Robertson Johnson</u>		4. DATE OF DEATH <u>February 7</u> 19 <u>61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-1893</u>
9. AGE (In years last birthday) <u>67</u> yrs		IF UNDER 1 YEAR <u>3</u> Months <u>7</u> Days	IF UNDER 24 HRS <u>7</u> Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>	
11. BIRTHPLACE (State or foreign country) <u>PERSON, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Bill Robertson</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Brooks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Daniel Johnson</u>		Address <u>222 Center St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY INFARCTION</u> DUE TO <u>OLD PNEUMATIC HEART DISEASE</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <u>HYPERTENSION & NEPHRITIS</u> DUE TO (c) <u>Indefinite</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 mins</u> <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>61</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE 1947</u> to <u>February 7, 1961</u> , that I last saw the deceased alive on <u>February 7, 1961</u> , and that death occurred at <u>9:30</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Wade</u>		ADDRESS (Street, city or town, state) <u>140 Oak Avenue</u> DATE SIGNED <u>2-7-61</u>	
PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u>		<u>Dundalk 22, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-11-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Arbutus, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> ADDRESS <u>802 Madison Avenue</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 10 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Charles R. Law</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

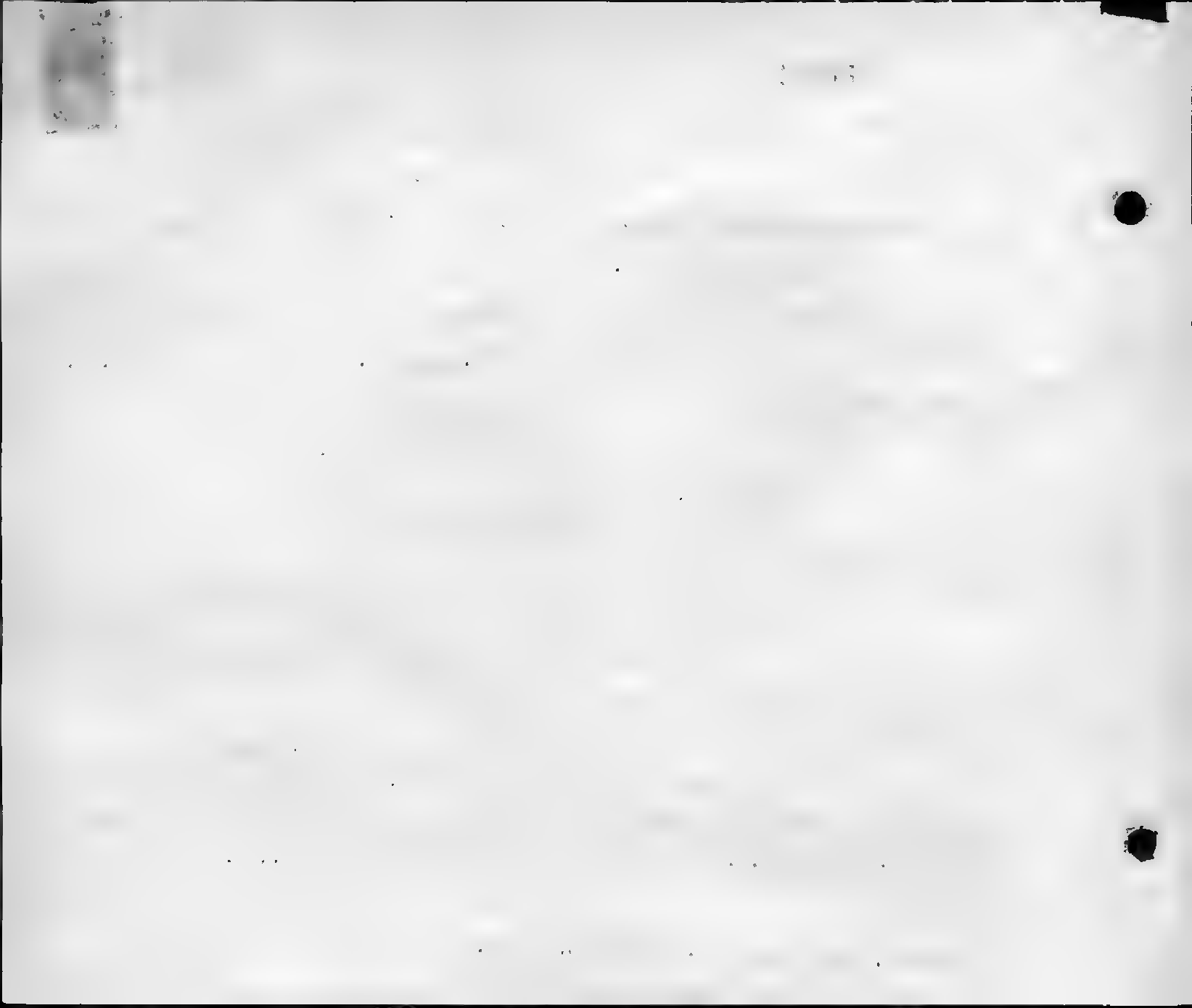
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1603

01583

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 97 Days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 514 Calvert Street	
3. NAME OF DECEASED (Type or print) THEODORE R. JOHNSON		4. DATE OF DEATH Month February Day 12 Year 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1905 September 19, /
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (County & State, or foreign country) Mt. Hope, W. Virginia	
13. FATHER'S NAME Frank Johnson		14. MOTHER'S MAIDEN NAME Polly MN: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		17. SOCIAL SECURITY NO. 197-05-5693	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 331X CEREbro-VASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF THE ESOPHAGUS DUE TO (c)		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 24 HOURS 1 YEAR	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
21. I certify that (this hospital) attended the deceased from November 7, 1960 to February 12, 1961 , that (we) last saw the deceased alive on February 12, 1961 , and that death occurred at 10:00 A.M. from the causes and on the date stated above.		22a. SIGNATURE Thomas F. Crahan, M.D.	
22b. DATE SIGNED 2/14/61		22c. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/16/61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		25a. REC'D BY REGISTRAR FEB 16 '61	
ADDRESS 1808 N. Monroe St., Balto. 17 Maryland		25b. REGISTRAR'S SIGNATURE Quinn S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

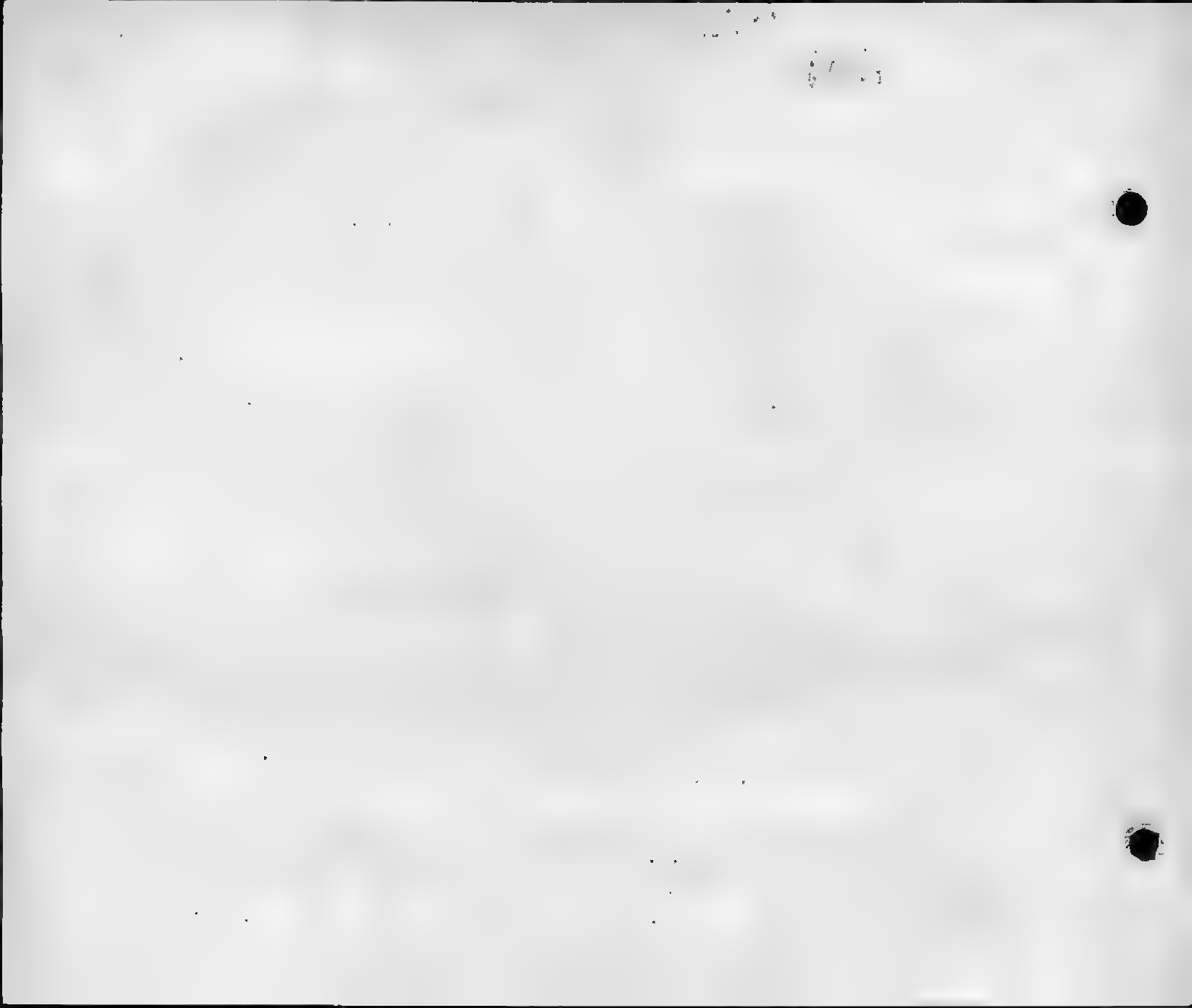
01585

1604

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> c. LENGTH OF STAY IN <u>17</u> days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata, Maryland</u> d. STREET ADDRESS <u>426 - P. O. Box</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sammie Lee Jones</u> 5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 9, 1884</u> 9. AGE (In years if under 1 year; rest birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Country & State, or foreign country) <u>Alabama</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry G. Kite</u> 14. MOTHER'S MAIDEN NAME <u>Clara V. Sallas</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>unknown</u> 17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO <u>Infarctive myocardial fibrosis</u> (c) <u>Arteriosclerotic cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1</u> month <u> </u> months <u> </u> years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 10</u> , 19 <u>61</u> to <u>Feb. 26</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Feb. 26</u> , 19 <u>61</u> , and that death occurred at <u>10PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachslar M.D.</u> M.D.		22b. DATE SIGNED <u>Feb. 27, 1961</u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar M.D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonville 26, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/1/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Rest Cemetery</u> 23d. LOCATION (City, town or county) <u>La Plata, Maryland</u> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Archibald F. Jones</u> ADDRESS <u>Home La Plata, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur E. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1605

Item 17 File G282 3-10-61 et

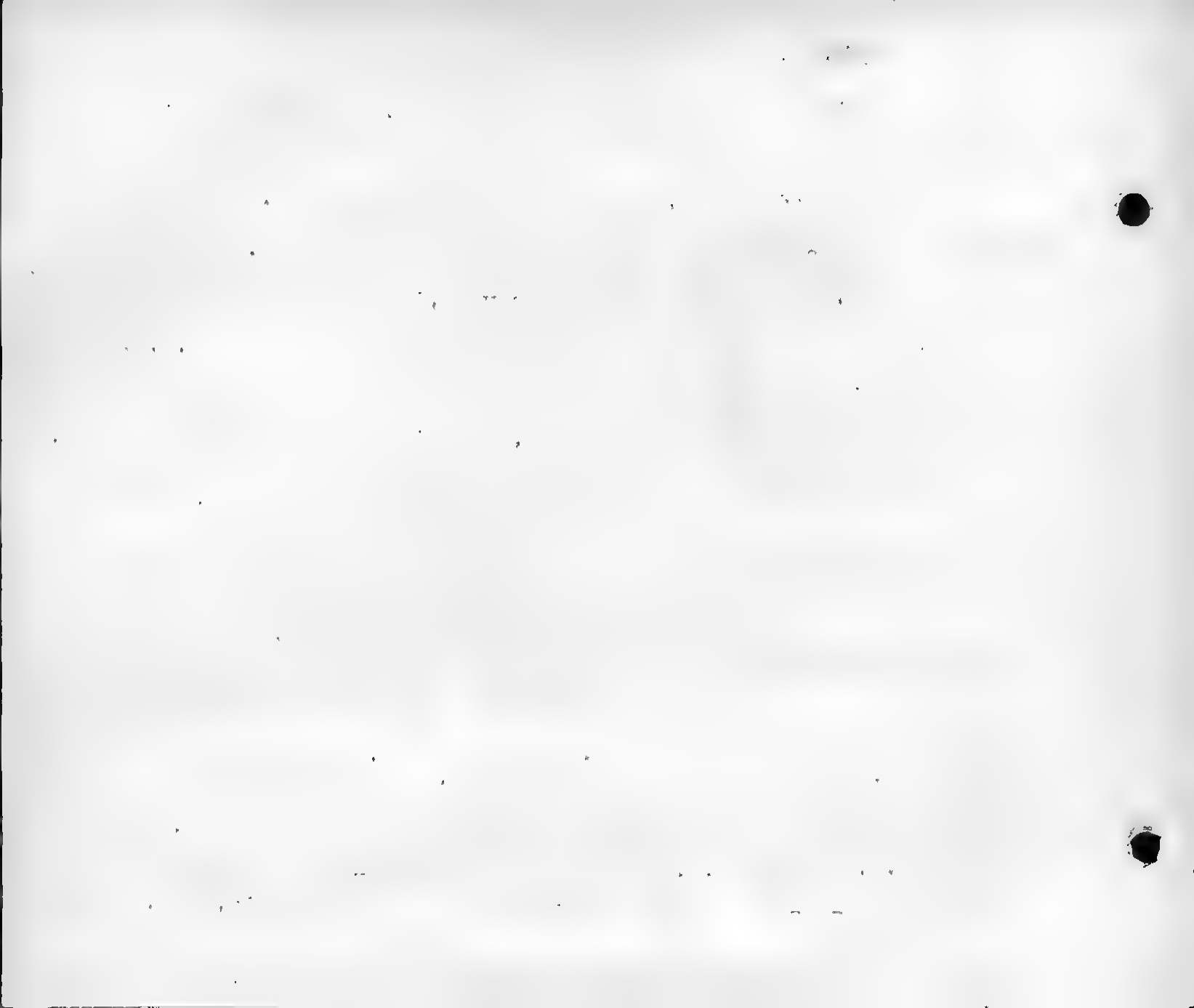
CERTIFICATE OF DEATH

Reg. Dist. No.

01584

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 905 Edmondson Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Catonsville d. STREET ADDRESS 905 Edmondson Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Jones Last Jones		4. DATE OF DEATH Month Feb. Day 24 Year 1961	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1873
9. AGE (In years last birthday) 87 yrs		IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min 19	IF UNDER 24 HRS Months 19 Days 19 Hours 19 Min 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Hanreit Scott		Address 905 Edmondson Av.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Insufficiency DUE TO 421.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arterio-sclerotic Heart Disease DUE TO 4 yrs (c) 11 months		INTERVAL BETWEEN ONSET AND DEATH I yr. & 3 1/2 Mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Virus Infection (pneumonitis) 6 wks.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 11th 1959 to Feb. 24th 1961 , that I last saw the deceased alive on Feb. 24th 1961 , and that death occurred at 4.30A M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 57 Winters Lane DATE SIGNED Feb. 24th 1961			
ACTUAL SIGNATURE C. F. Maloney, M.D.		PHYSICIAN'S NAME (Type) C. F. Maloney, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-28-61	
22c. NAME OF CEMETERY OR CREMATORY Western Bazaar Cem		22d. LOCATION (City, town, or county) (State) Catonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frances A. Hemminger		ADDRESS 378 W.	
24a. REC'D BY REGISTRAR DATE MAR 1 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

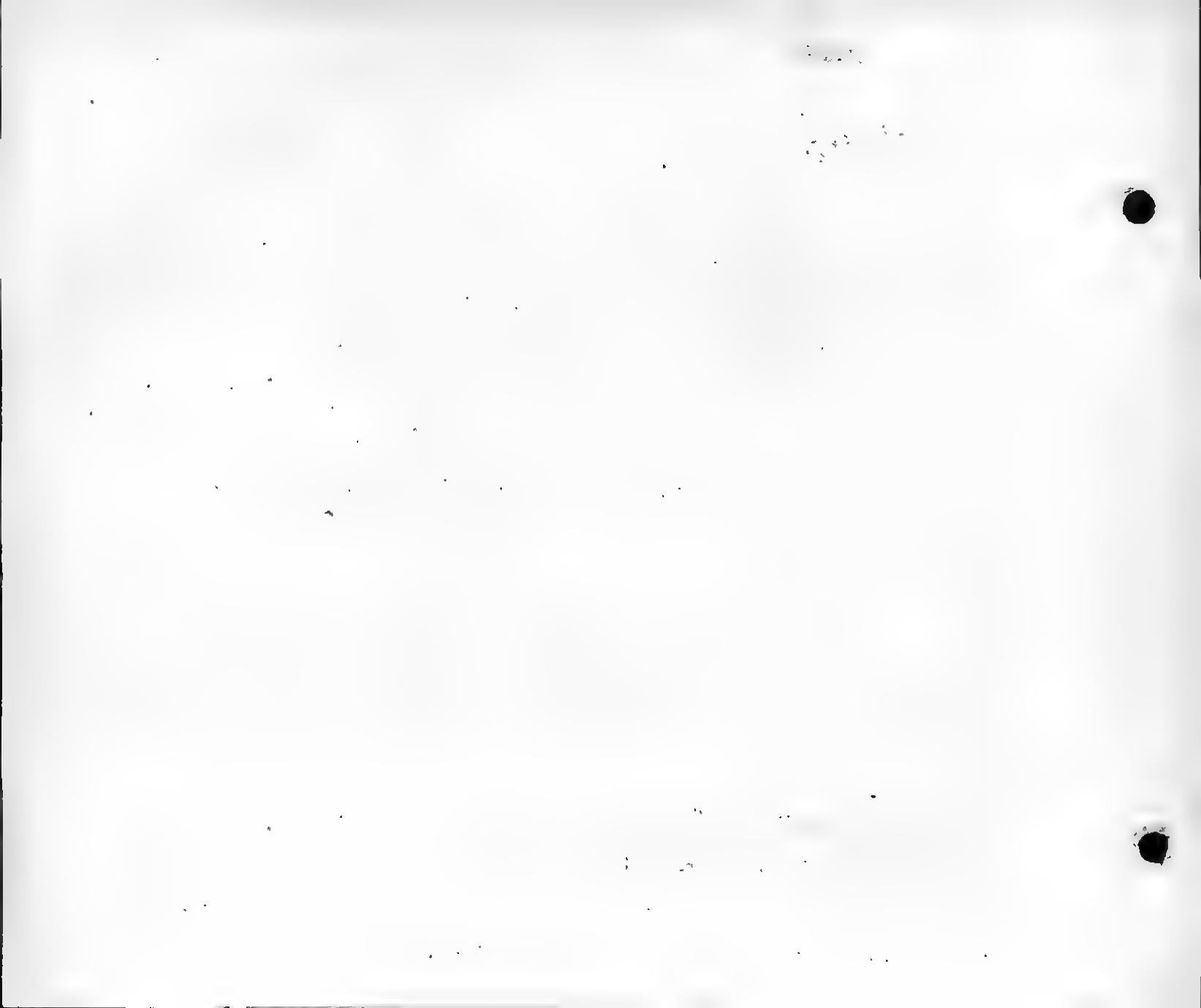
(M-2) Frances A. Hemminger



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

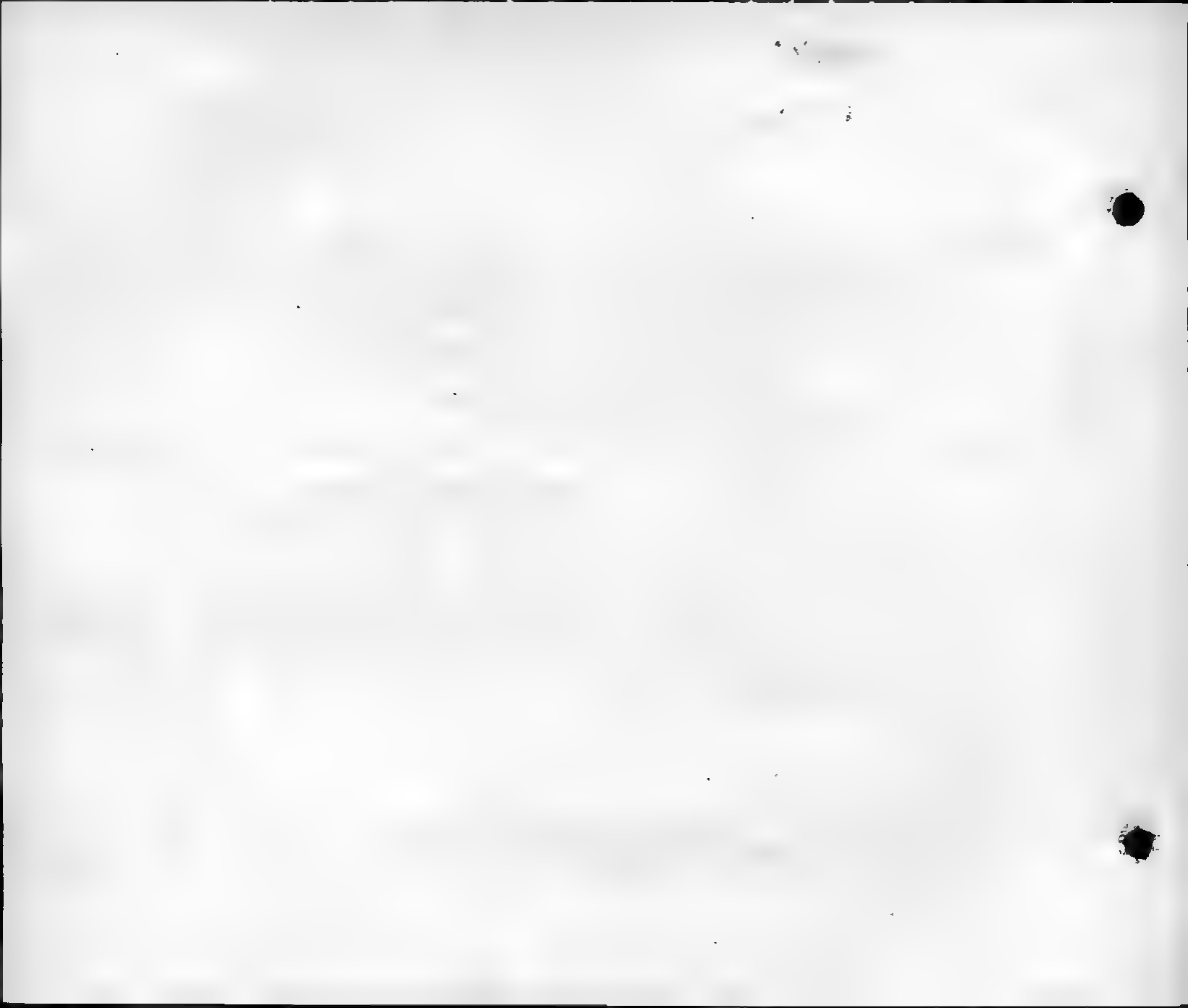
VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
1606 CERTIFICATE OF DEATH											
Reg. Dist. No. 01586											
1. PLACE OF DEATH a. COUNTY BALTIMORE				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22				c. LENGTH OF STAY IN LIFE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION 3426 YORKWAY				d. STREET ADDRESS 3426 YORKWAY				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last VICTOR ALBERT JONES				4. DATE OF DEATH Month Day Year FEBRUARY 26, 1961 19							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 9, 1877		9. AGE (In years last birthday) yrs. 83		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamon Retired				10b. KIND OF BUSINESS OR INDUSTRY 14 Yrs Harbor Board				11. BIRTHPLACE (State or foreign country) Charleston South Carolina			
12. CITIZEN OF WHAT COUNTRY?											
13. FATHER'S NAME Albert O. Jones				14. MOTHER'S MAIDEN NAME Estelle CROCKER							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes				16. SOCIAL SECURITY NO. NONE				INFORMANT 3426 Yorkway Dundalk 22 Md. MRS AUGUSTA A. JONES			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) 10 YRS (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from May 1960 to 2/26/61 , 1961, that I last saw the deceased alive on 2/23/61 , 1961, and that death occurred at 5 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W. E. Baermann M.D. 3401 Dundalk Ave. PHYSICIAN'S NAME (Type) WILLIAM E. BAERMANN											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/2/61				22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY			
22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND											
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HENRY SANDER & SONS INC. BALTIMORE MD				24a. REC'D BY REGISTRAR DATE MAR 1 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			



1607
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 01587

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>3 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1006 COLLWOOD Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>MAY</u> Last <u>KAISER</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>17</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 6, 1886</u>	9. AGE (In years last birthday) <u>74</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RICHARD BRANDLE</u>				14. MOTHER'S MAIDEN NAME <u>SARAH ARNOLD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. HERSHAW 1006 COLLWOOD Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Acute Toxic failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rapid vascular renal disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tumor in abdomen was determined in gross</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> 19 <u>61</u> to <u>Feb 17</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>Feb 6</u> 19 <u>61</u> and that death occurred at <u>8:55</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Geo. M. Kieffer</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE M. KIEFFER MD</u>				22d. ADDRESS <u>7470 Wash. Blvd. Balt. Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-21-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LODGE PARK</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schwarz</u> ADDRESS <u>Funeral Home 2101 Frederick Ave.</u>				25a. REC'D BY REGISTRAR <u>FEB 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

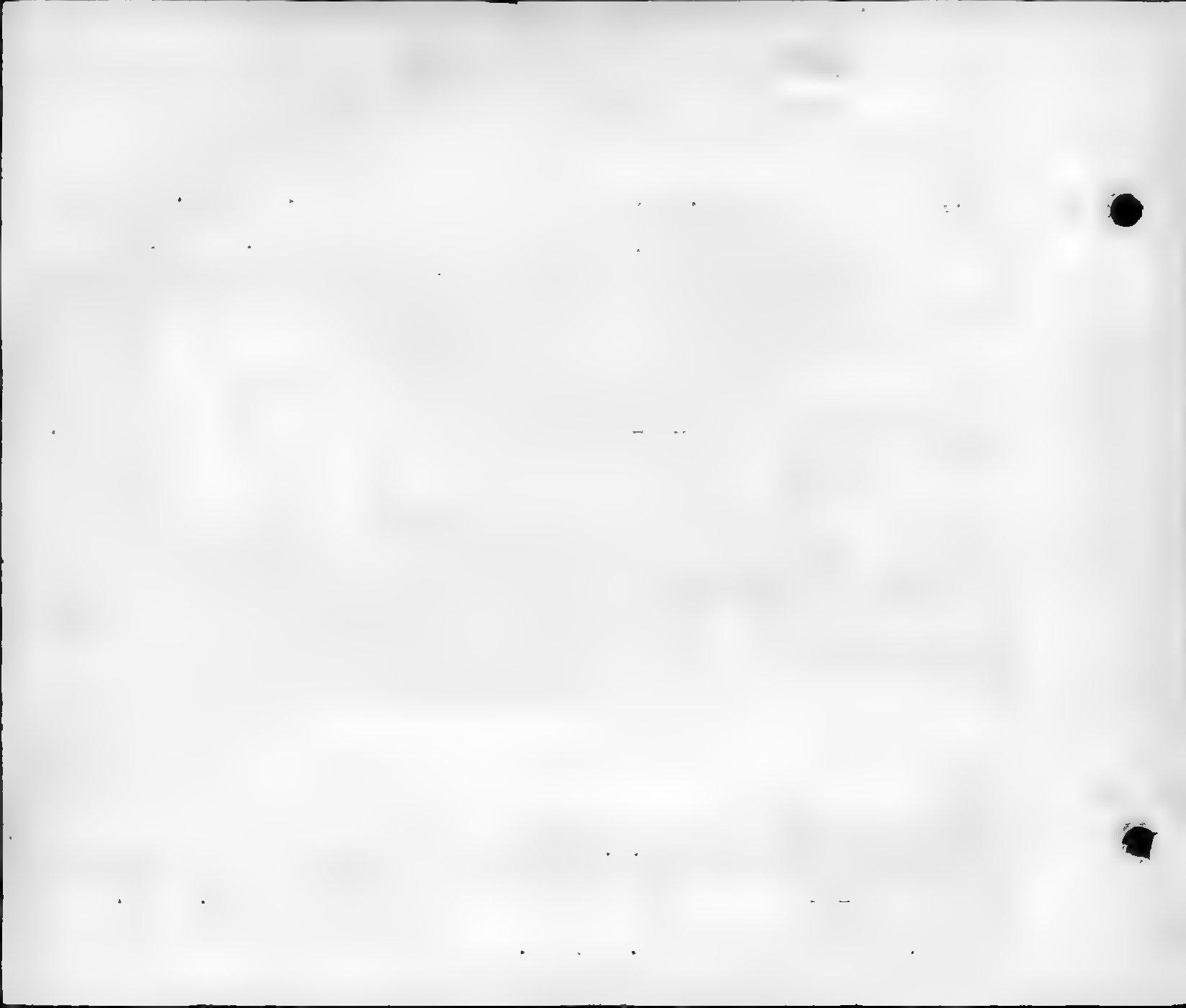
1608

CERTIFICATE OF DEATH

Reg. Dist. No. 01588

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere			
c. LENGTH OF STAY IN 1b 34 yrs.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res., 3019 Ritchie Ave. 19, Md.				d. STREET ADDRESS 3019 Ritchie Ave. 19, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALMA Middle S. Last Kauffmann				4. DATE OF DEATH Month Feb. Day 5 Year 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 22, 1877	
9. AGE (In years last birthday) yrs 85		IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min.		IF UNDER 24 HRS Months 19 Days 19 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Housekeeping				10b. KIND OF BUSINESS OR INDUSTRY Germany		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? Germany ✓							
13. FATHER'S NAME August Butzke				14. MOTHER'S MAIDEN NAME Caroline Gunther			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, up or unknown) No (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO 220-24-3365			
17. INFORMANT Henry & Eric Ratsch				Address 3019 Ritchie Ave. 19			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Art. Sclerotic Heart Disease DUE TO (c) 10 yrs						INTERVAL BETWEEN ONSET AND DEATH 60 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1-1-1961 to 2-5-1961 , that I last saw the deceased alive on 2-3-1961 , and that death occurred at N.A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 520 D St. Balt DATE SIGNED 2-6-61							
ACTUAL SIGNATURE Roger D. Windsor				M.D. 520 D St. Balt			
PHYSICIAN'S NAME (Type) Roger D. Windsor M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-8-1961		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Blvd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA				ADDRESS 7922 Wise Ave. 22, Md.		24a. REC'D BY REGISTRAR DATE FEB 9 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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1609
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
01583

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <u>1010 COLLWOOD RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PAULINE L. KEARNEY</u>		4. DATE OF DEATH Month Day Year <u>FEB. 5, 1961</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 26, 1896</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CASHIER, WESTVIEW SWIMMING POOL</u>		11. BIRTHPLACE (State or foreign country) <u>M.D.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>LUDWIG HALSMANN</u>	
14. MOTHER'S MAIDEN NAME <u>ELIZABETH. — — —</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>219-40-5175</u>		17. INFORMANT Address <u>MR. ERNEST BROWN, 1010 COLLWOOD RD. #25</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE CORONARY THROMBOSIS</u> 420.1 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE</u> DUE TO (c) <u>DISEASE</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> 19 <u>54</u> to <u>2/5</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2/5</u> 19 <u>61</u> , and that death occurred at <u>3:20</u> AM, from the causes and on the date stated above			
22a. SIGNATURE <u>John H. Shaw M.D.</u> M.D.		22b. DATE SIGNED <u>2/7/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u>		22d. ADDRESS <u>5804 EDMONDSON AVE. BALDWIN, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2/8/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LUDLOW PARK CEMET.</u>	23d. LOCATION (City, town, or county) (State) <u>BALTO. M.D.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE F.W. DIR.</u> ADDRESS <u>4101 EDMONDSON AVE.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 8 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kova</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

16 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01590

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Texas, Cockeysville P.O.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Texas, Cockeysville P.O.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) York Road near Padonia Road				d. STREET ADDRESS York Road near Padonia Road			
3. NAME OF DECEASED (Type or print) First CHARLES Middle GROVER Last KIMSEY				4. DATE OF DEATH Month February Day 12 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 20, 1884	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Auto Salesman		10b. KIND OF BUSINESS OR INDUSTRY Autos Retail		11. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Kimsey				14. MOTHER'S MAIDEN NAME ? Patterson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 215-01-1040		17. INFORMANT Family Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 10 yrs (c) 10 yrs						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 10 yrs							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles F. O'Donnell				DATE SIGNED 2/12/61			
EXAMINER'S NAME (Type) Charles F. O'Donnell				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 16, 1961		22c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery		22d. LOCATION (City, town, or county) (State) Catonsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland				24a. REC'D BY REGISTRAR FEB 17 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

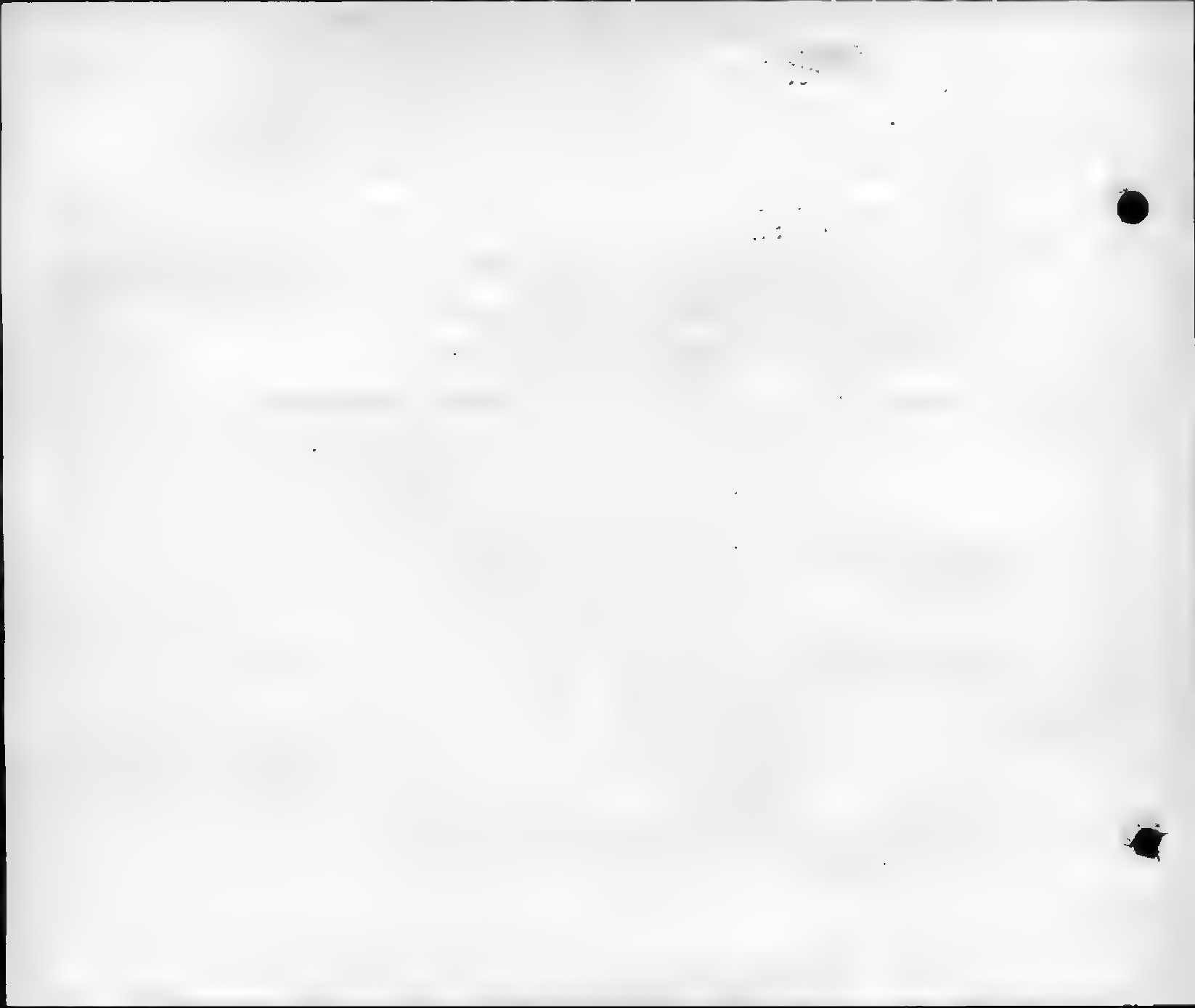


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1611

01591

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY HALL.				c. LENGTH OF STAY IN 1b 20 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4137 India Ave.				d. STREET ADDRESS 4137 India Ave.			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last KLEIN				4. DATE OF DEATH Month FEB Day 17 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 29, 1896	
9. AGE (in years last birthday) 64 yrs		IF UNDER 1 YEAR Months 6 Days 4		IF UNDER 24 HRS Hours 17 Min 17			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST				10b. KIND OF BUSINESS OR INDUSTRY ARMCO STEEL		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HERMAN. KLEIN				14. MOTHER'S MAIDEN NAME FRANCES PAYNE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-01-6892		17. INFORMANT Address Mrs. Mildred Klein, 4137 India Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency, Severe DUE TO (b) Asthmatic Bronchitis + Bronchopneumonia DUE TO (c) 1 wk. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Asthma							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from May 20, 1959 , to Feb 17, 1961 , that (I) (we) last saw the deceased alive on Feb 16, 1961 , and that death occurred at 4:20 AM , from the causes and on the date stated above.							
22a. SIGNATURE <i>Theodore E. Evans</i>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) THEODORE E. EVANS				22d. ADDRESS 9660 Belair Rd. Md. 6			
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB 20, 1961		23c. NAME OF CEMETERY OR CREMATORY PARWOOD CEM.		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Lassahn Funeral Home</i>				ADDRESS 7401 Belair Rd #6, Md.		25a. REC'D BY REGISTRAR DATE FEB 20 '61	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1612

CERTIFICATE OF DEATH

11-11-62 2-16-61 et

01592

1 PLACE OF DEATH a. COUNTY BALTO.				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN 1b 24 yrs				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reswood State Training School				d. STREET ADDRESS 1142 The Terrace																			
3. NAME OF DECEASED (Type or print) First Middle Last ANNE Virginia Kohler				4. DATE OF DEATH Month Day Year 2 6 1961																			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-9-31 29		9. AGE (In years last birthday) yrs 30		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Jesse Earl Kohler				14. MOTHER'S MAIDEN NAME ANNE Virginia Wright																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. ---				17. INFORMANT Reswood Records				Address Owings Mills, Md											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute and chronic 491X DUE TO bronchopneumonia com- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO plexiating mongolian idiocy (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)				(County) (State)											
21 I certify that (I) (this hospital) attended the deceased from 11/37 19 36 to 2-6 19 61 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 6:30 A.M. from the causes and on the date stated above																							
22a. SIGNATURE Peter W. Rieckert, Pathologist				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED 2-6-61															
22c. PHYSICIAN'S NAME (Type) Peter W. Rieckert				22d. ADDRESS 4307 Mainfield Ave, Balto 14																			
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation				23b. DATE THEREOF 2/7/1961				23c. NAME OF CEMETERY OR CREMATORY Eden Hill Cemetery				23d. LOCATION (City, town, or county) (State) Washington D.C.											
24. FUNERAL DIRECTOR'S SIGNATURE Charles Rouzer				ADDRESS 18450 1st Avenue Ind.				25a. REC'D BY REGISTRAR DATE FEB 10 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

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2



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

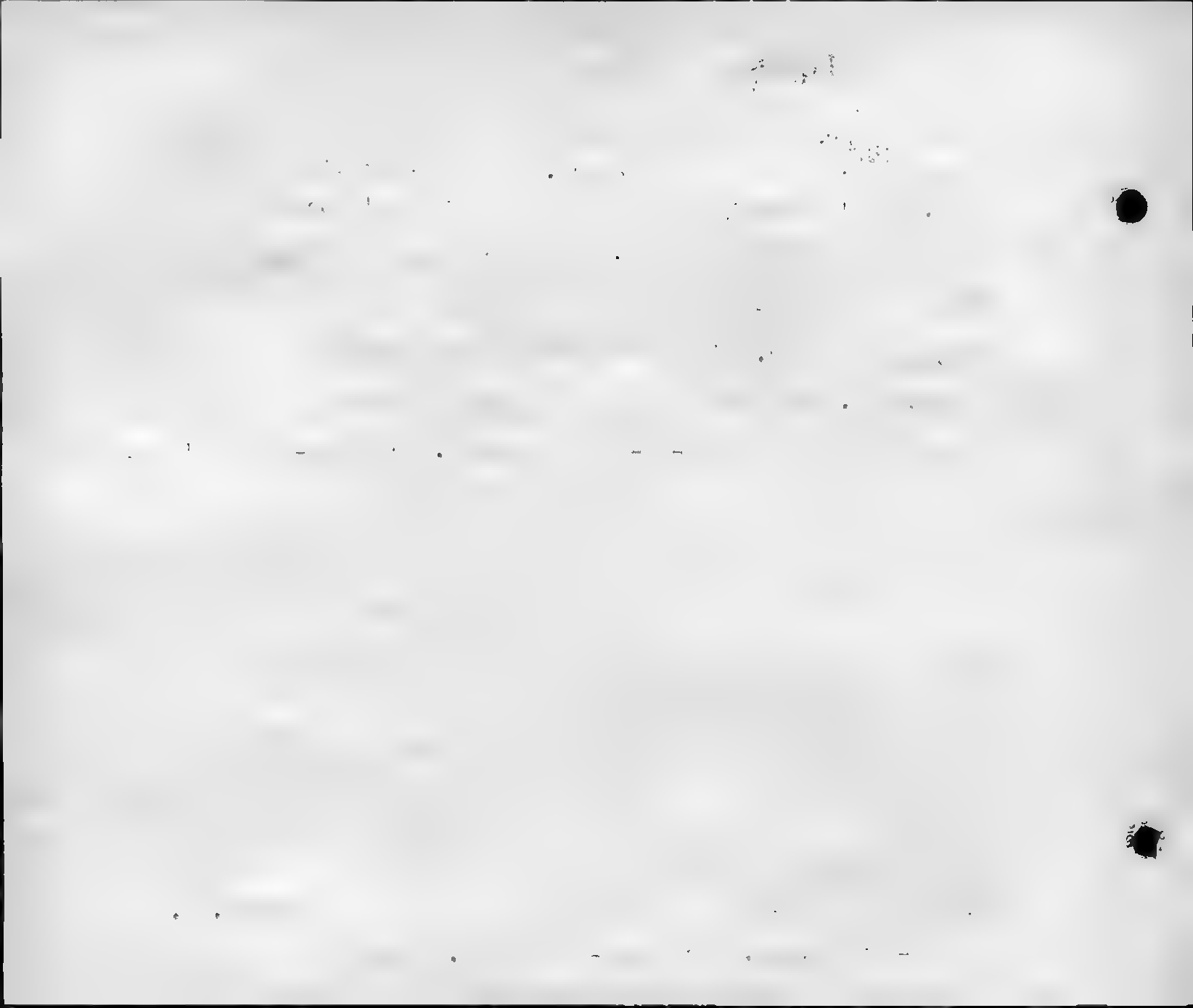
1613 Item 4 Film 6-25-61 et CERTIFICATE OF DEATH

01593

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside of corporate limits write RURAL and give nearest town) <u>Brooklandville</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>St. Paul's School</u> d. LENGTH OF STAY IN <u>1 1/2</u> Yrs.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Baltimore</u> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklandville</u> h. STREET ADDRESS <u>St Paul's School</u> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>E.</u> Last <u>Kressler</u>		4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1961</u>		5. SEX <u>Male</u>			
6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <u>7/28/02</u>			
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u>		11. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>14</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Super.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>School Buildings</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Walter C. Kressler</u>			
14. MOTHER'S MAIDEN NAME <u>Agnes Cochrane</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>577-10-0038</u>				17. INFORMANT <u>James V. Kressler-St Paul's School</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> (b) <u>1420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NA. DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER!) _____							
20c. TIME OF INJURY Month, Day, Year <u>Feb 12 1961</u> Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		20g. (County) _____		20h. (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 12</u> , 19 <u>61</u> , to <u>Feb 13</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Feb 13</u> , 19 <u>61</u> , and that death occurred at <u>11</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Francis T Daly</u>		22b. DATE SIGNED <u>2/13/61</u>		22c. PHYSICIAN'S NAME (Type) <u>FRANCIS T DALY</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/14/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>			
23d. LOCATION (City, town or county) <u>Baltimore, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Towson, Inc. York Road-Towson, Md.</u>					
25a. REC'D BY REGISTRAR <u>DATE FEB 15 '61</u>		25b. REGISTRAR'S SIGNATURE <u>C. E. S. & K. S.</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, and 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01594

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River	
c. LENGTH OF STAY IN lb 5 Yrs.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Catherine Middle Krisman Last Krisman		4. DATE OF DEATH Month February Day 27 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/89
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Lukaszewski		14. MOTHER'S MAIDEN NAME Pauline Kuczynski	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (1) yes, give war or dates of service		16. SOCIAL SECURITY NO. 212-01-9155	
17. INFORMANT Michael Krisman		Address 1106 Orems Rd, Balto, 20, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 153.9 DUE TO (c) 153.9		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 17.011	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 , 19 61 , to 27 , 19 61 , that I last saw the deceased alive on 27 , 19 61 , and that death occurred at 3:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE George A. Weber M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/2/61	22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery	22d. LOCATION (City, town, or county) (State) 6515 Boston St, Balto, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George A. Weber 705 South Ann Street		24a. REC'D BY REGISTRAR DATE FEB 28 '61	24b. REGISTRAR'S SIGNATURE C. L. S. K. K.

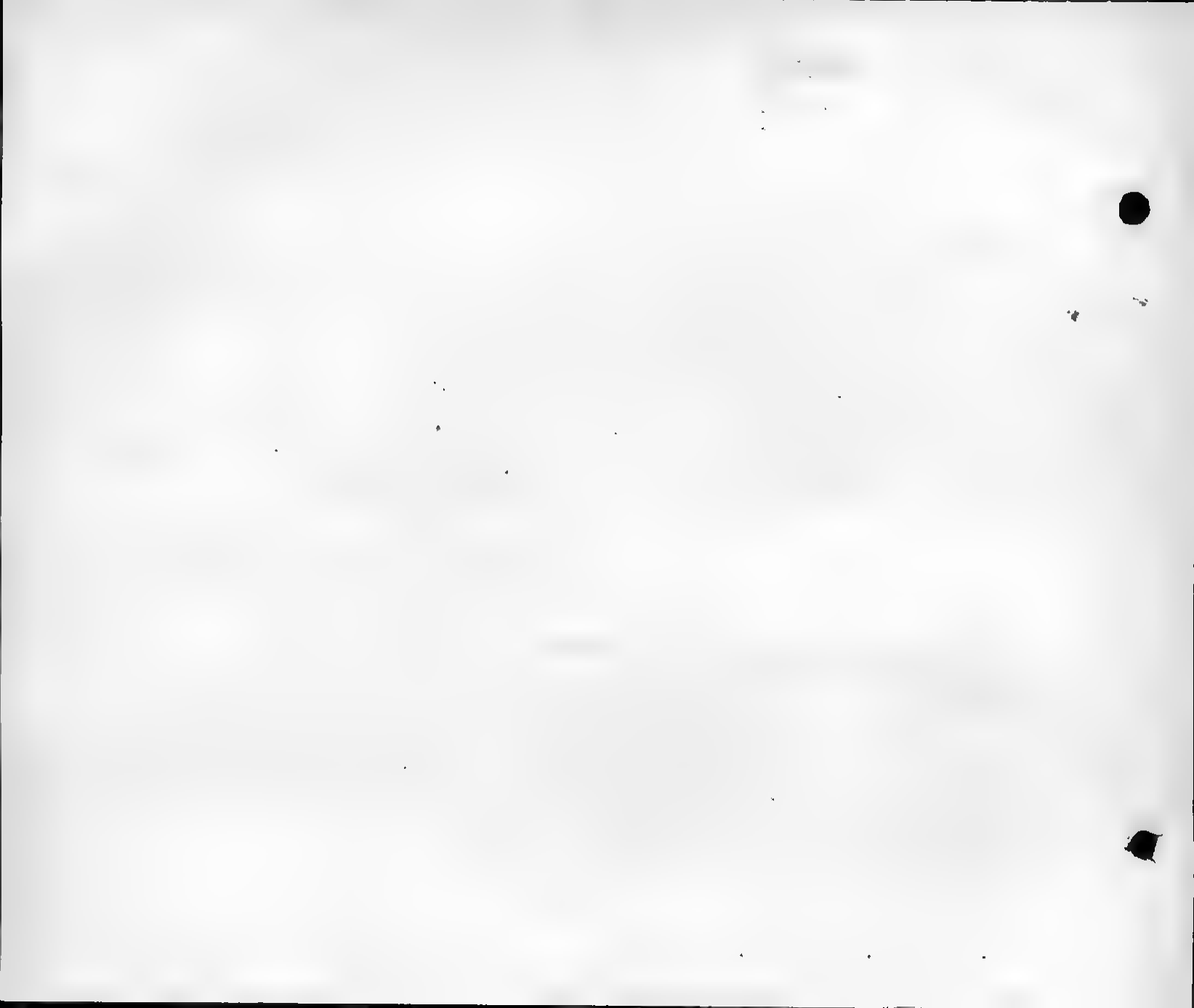
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01595

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ...	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 1 YEAR.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVIERA BEACH	
		d. STREET ADDRESS 158 PARK DRIVE	
3. NAME OF DECEASED (Type or print) JOHN RAYMOND LANDAUER		4. DATE OF DEATH Month FEB Day 18 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-26-1891
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES E. LANDAUER		14. MOTHER'S MAIDEN NAME MARY TONGE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-01-1390A	
17. INFORMANT Frank L. Smith		Address Cockeysville, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio			
DUE TO (b) Vascular Disease			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-29 1960 to 2-18 1961 , that (I) (we) last saw the deceased alive on 2-17 1961 , and that death occurred at 4:50 P. from the causes and on the date stated above			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 2/18/61	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-21-61	
23c. NAME OF CEMETERY OR CREMATORY Landon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR DATE FEB 21 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

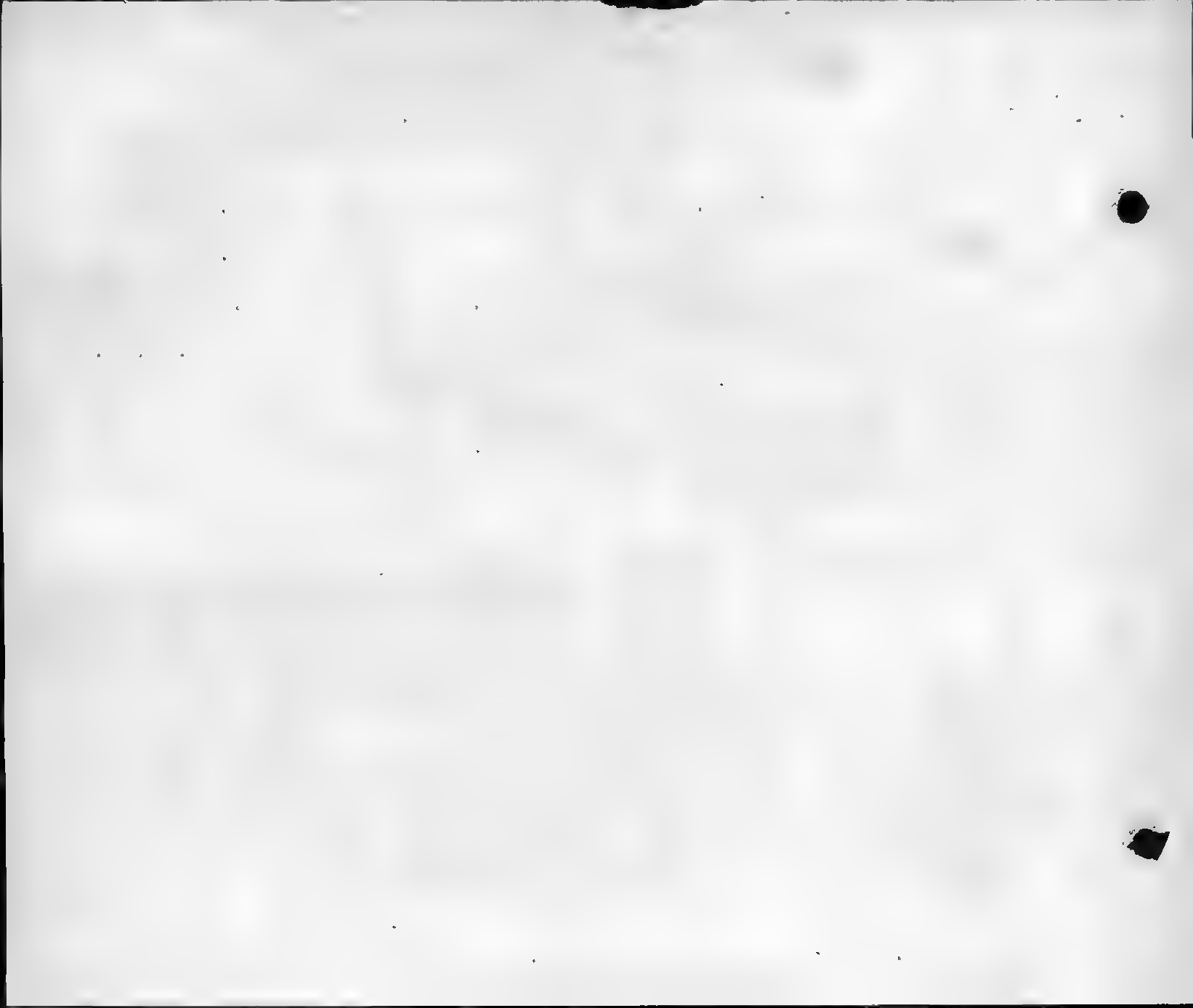
01596

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7218 Eastern Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ENOCH</u> Middle <u>W.</u> Last <u>LAUER</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> , Year <u>19 61</u>	
5. SEX <u>W white</u>	6. COLOR OR RACE <u>M male</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 4, 1896</u>
9. AGE (In years last birthday) <u>64 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>produce dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Jacob Lauer</u>	
14. MOTHER'S MAIDEN NAME <u>Lydia Cocker</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W W I</u>	
16. SOCIAL SECURITY NO. <u>216 18 0450</u>		17. INFORMANT Address <u>Anna M. Shinnamon 152 Oaklee Village #29</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> <u>420.1</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Int. Sclerosis</u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack E Collins</u> EXAMINER'S NAME (Type) <u>Jack E Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>2-22-61</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>2/24/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>	
22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>	
ADDRESS <u>4107 Wilkens Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 27 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



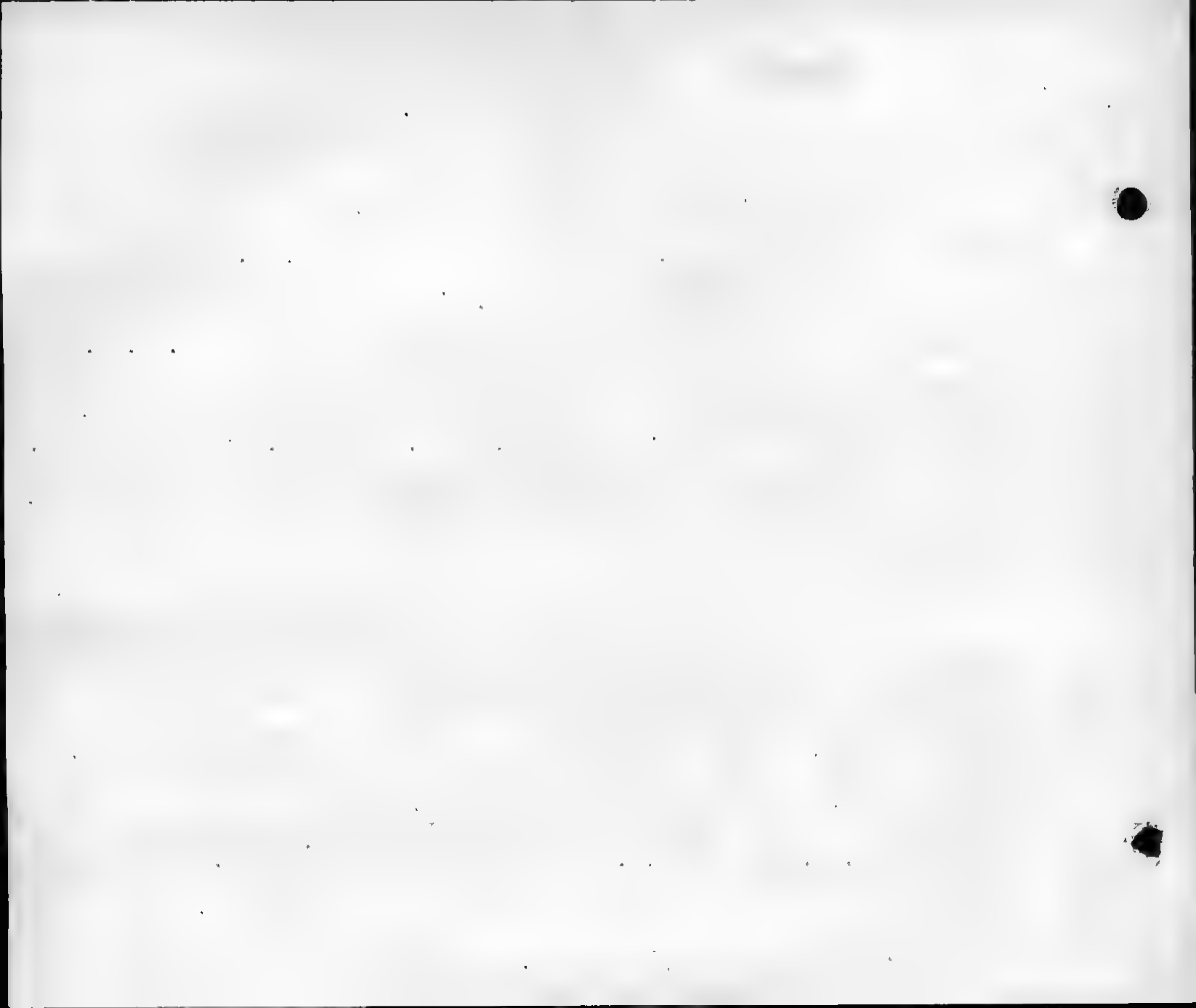
TO ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1617

01597

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus c. LENGTH OF STAY IN 1b Baltimore (Arbutus)		2. USUAL RESIDENCE (Where deceased lived If institution Res dence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Arbutus) d. STREET ADDRESS 5620 Oakland Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sophie E. Lauer		4. DATE OF DEATH Month Feb. Day 22 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 28, 1908
9. AGE (In years last birthday) 53 yrs		10. IF UNDER 1 YEAR Months 12 Days 18 Hours 00 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryladd	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Walter August		14. MOTHER'S MAIDEN NAME Fruzina Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 212 05 2474	
17. INFORMANT Address Lawrence H. Lauer, Sr. 5620 Oakland Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic sarcoma advance vertebral column and abdominal area DUE TO Primary source---sarcoma of spinal meninges lumbar area Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Cachexia		INTERVAL BETWEEN ONSET AND DEATH 12-18 mos. 1956+- 18 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 12:50 to 2-22-61 19, that (1) the last saw the deceased alive on 2-12-61 19, and that death occurred at 3:40 from the causes and on the date stated above.			
22a. SIGNATURE R. V. Rangle, M.D.		22b. DATE SIGNED 2-22-61	
22c. PHYSICIAN'S NAME (Type) R. V. Rangle, M.D.		22d. ADDRESS 2938 St. Paul Street	
23a. BURIAL, CREMATION, REMOVAL, Specify Burial	23b. DATE THEREOF 2/25/61	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	23d. LOCATION (City, town, or county) (State) Elkridge, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR DATE FEB 27 '61	
ADDRESS 4107 Wilkens Ave.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1618

CERTIFICATE OF DEATH

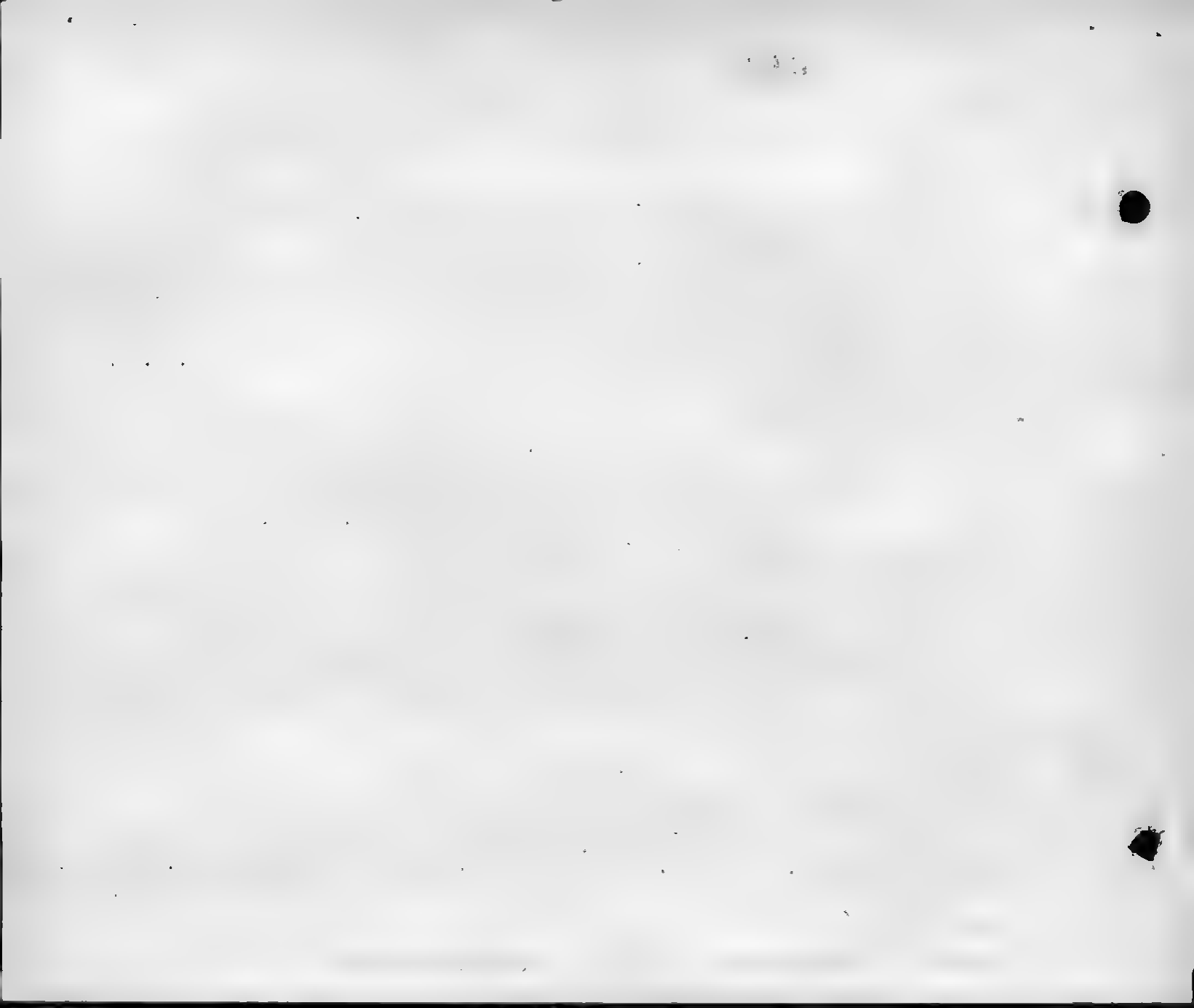
01598

1. PLACE OF DEATH COUNTY Baltimore M b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 171 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 16 d. STREET ADDRESS 3901 Woodhaven Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LORRAINE H. LAWSON		4. DATE OF DEATH Month February Day 20 Year 19 61	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 14, 1917
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 1 Days 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacologist		10b. KIND OF BUSINESS OR INDUSTRY Army Chemical Center) Baltimore, Maryland	
11. BIRTHPLACE (Country & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Winston Lawson, Sr.		14. MOTHER'S MAIDEN NAME Rosie Maitland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO 217-16-8606	
17. INFORMATION Clinical Records, VAH, Baltimore 18, Maryland		18. ADDRESS Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, LEFT UPPER LOBE WITH METASTASES TO REGIONAL LYMPH NODES, LIVER, ADRENALS, LEFT KIDNEY, SPLEEN AND BRAIN DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation July, 1960. - Removal extradural tumor.		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. CITY OR TOWN (County) (State)
21. I certify that (this hospital) attended the deceased from September 2, 1960, to February 20, 1961 , that (I) (we) last saw the deceased alive on Feb. 20, 1961 , and that death occurred at 5:45 P. M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Thomas F. Crahan</i>		22b. DATE SIGNED 2/21/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 24, 61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) Baltimore (State) 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles B. Lewis Mortuary, Baltimore, Maryland		25a. REC'D BY REGISTRAR DATE FEB 24 '61	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no other event, within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no other event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no other event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

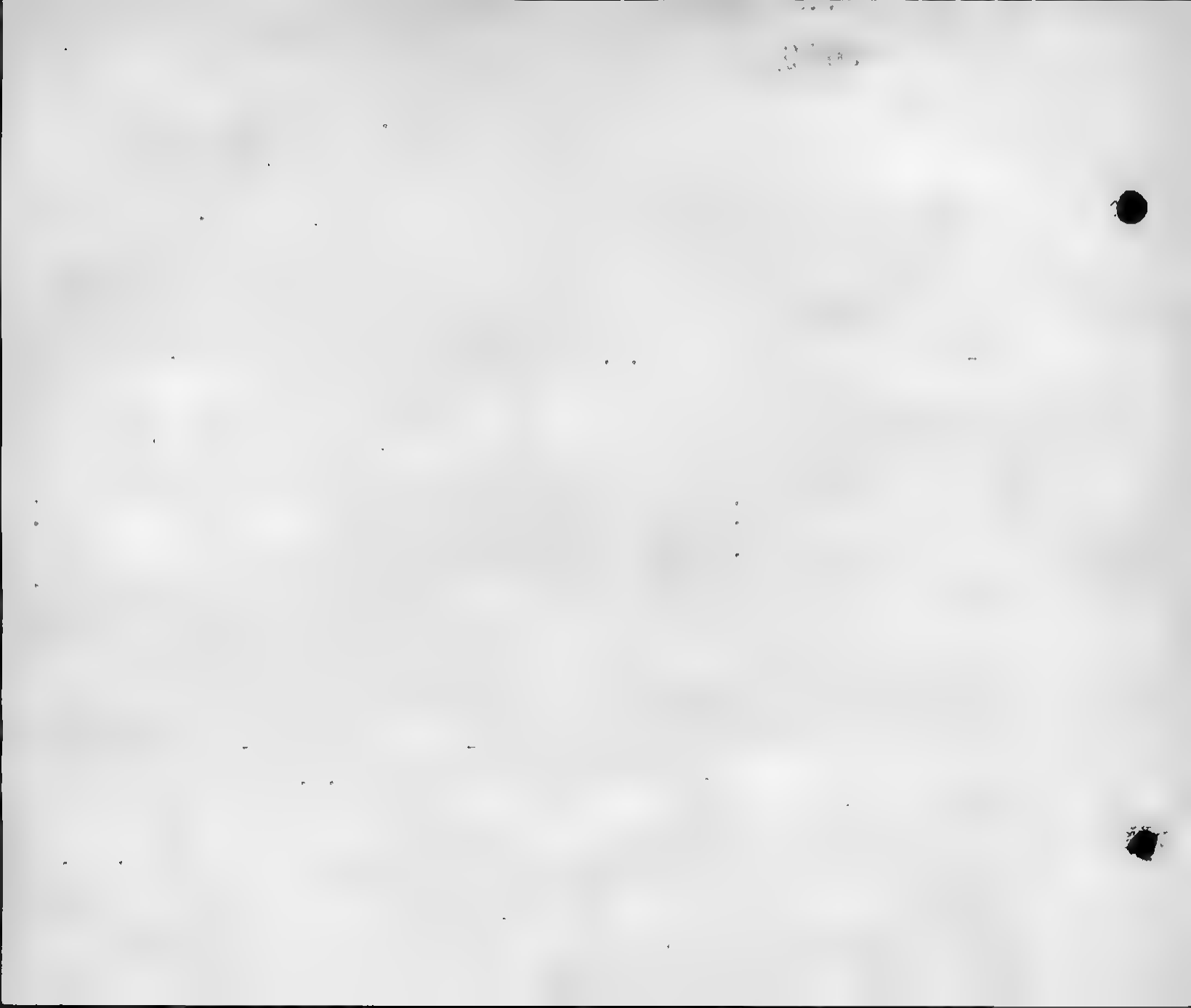
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1619

CERTIFICATE OF DEATH

01599

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN b. <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shady Nook Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>407 Brice Street (north)</u> d. STREET ADDRESS <u>Baltimore, 23, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>LEDIG</u> Middle <u>LEDIG</u> Last 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>2/18/76</u> 9. AGE (in years last birthday) <u>84</u> IF UNDER 1 YEAR: Months <u>8</u> Days <u>4</u> IF UNDER 24 HRS. Min. <u>19</u>		4. DATE OF DEATH <u>Feb. 12</u> 19 <u>61</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret-Car Man</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>B & O R.R.</u> 11. BIRTHPLACE (Country & State, or foreign country) <u>Hungary</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Ledig</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> <u>Helen Mathieu, dght, 8728 Conmar Rd, Zone 20</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>1. Auricular Fibrillation</u> DUE TO <u>2. Cardio-Vascular Renal Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3. Urinary Incontinence</u> DUE TO <u>4. Senility</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u> <u>5 yrs.?</u> <u>2 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-7</u> 19 <u>61</u> to <u>2-12</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2-12</u> 19 <u>61</u> and that death occurred <u>10:35 p.m.</u> on the date stated above.			
22a. SIGNATURE <u>George E. Urban</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>George E. Urban M.D.</u>		22d. ADDRESS <u>805 Frederick Ave. Balto. 28, Md.</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>2/15/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schinunek</u> ADDRESS <u>3331 Brehms Lane</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 16 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1620

CERTIFICATE OF DEATH

Reg. Dist. No.

016,00

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)				c. LENGTH OF STAY IN 1b 21 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 8018 Stansbury Road				d. STREET ADDRESS 8018 Stansbury Road			
3. NAME OF DECEASED (Type or print) EDNA ANDERSON LEGARE				4. DATE OF DEATH February 15, 1961			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 6, '84		9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR Months 1 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Anderson				14. MOTHER'S MAIDEN NAME Mary Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 212-36-9327		17. INFORMANT Herman Keith Legare		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) coronary insufficiency with heart block. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension, arteriosclerosis, 31 years. DUE TO (c) Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1961 to Feb 15, 1961 , that I last saw the deceased alive on Feb 15, 1961 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lauriston L. Keown, M.D.				ADDRESS (Street, city or town, state) 1938 Linden Avenue		DATE SIGNED 2/17/61	
PHYSICIAN'S NAME (Type) Lauriston L. Keown, M.D.				Baltimore 17, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/61		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial		22d. LOCATION (City, town, or county) (State) Dorsey, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md				24a. REC'D BY REGISTRAR FEB 20 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Francis	

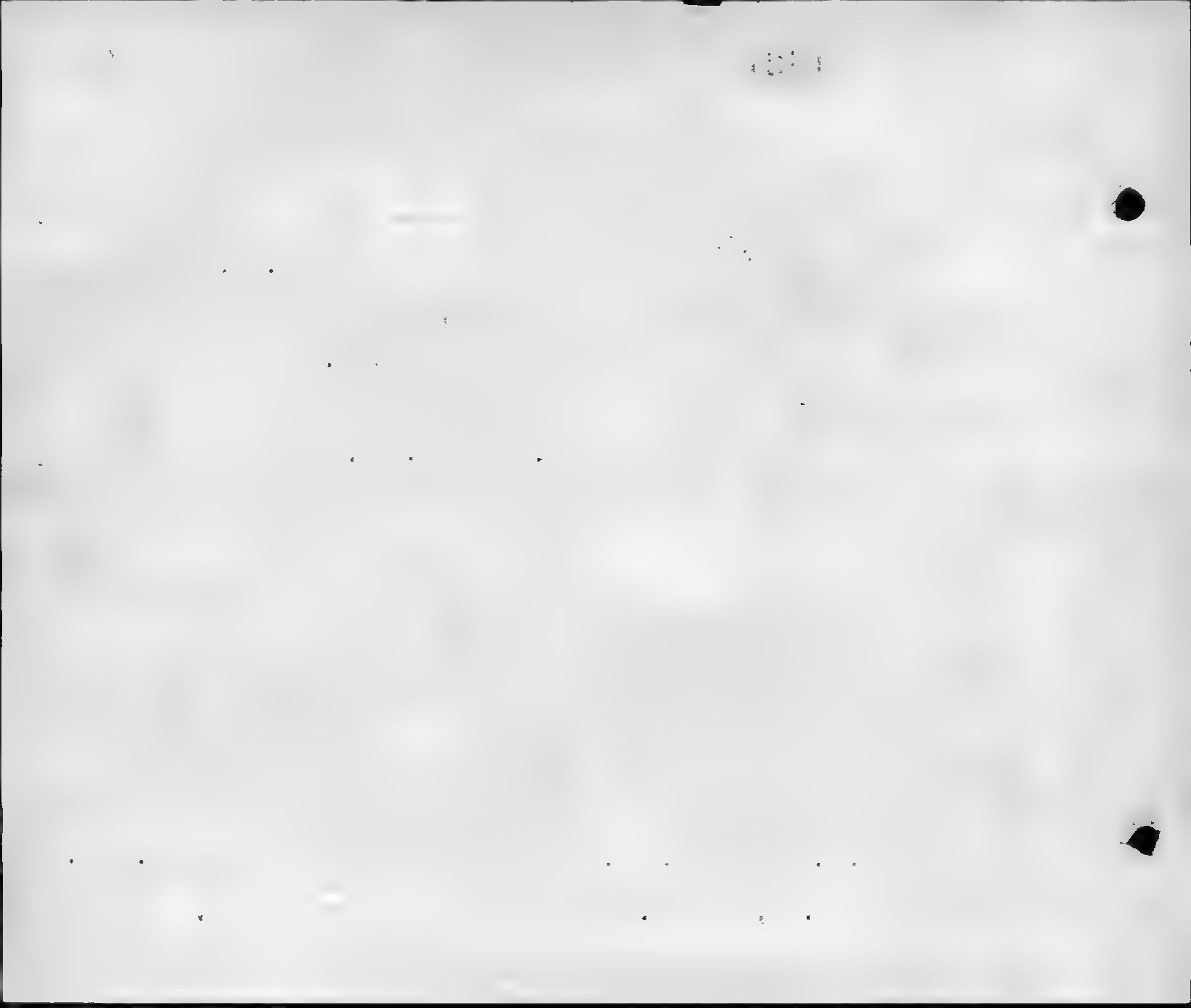


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1621 CERTIFICATE OF DEATH 01601

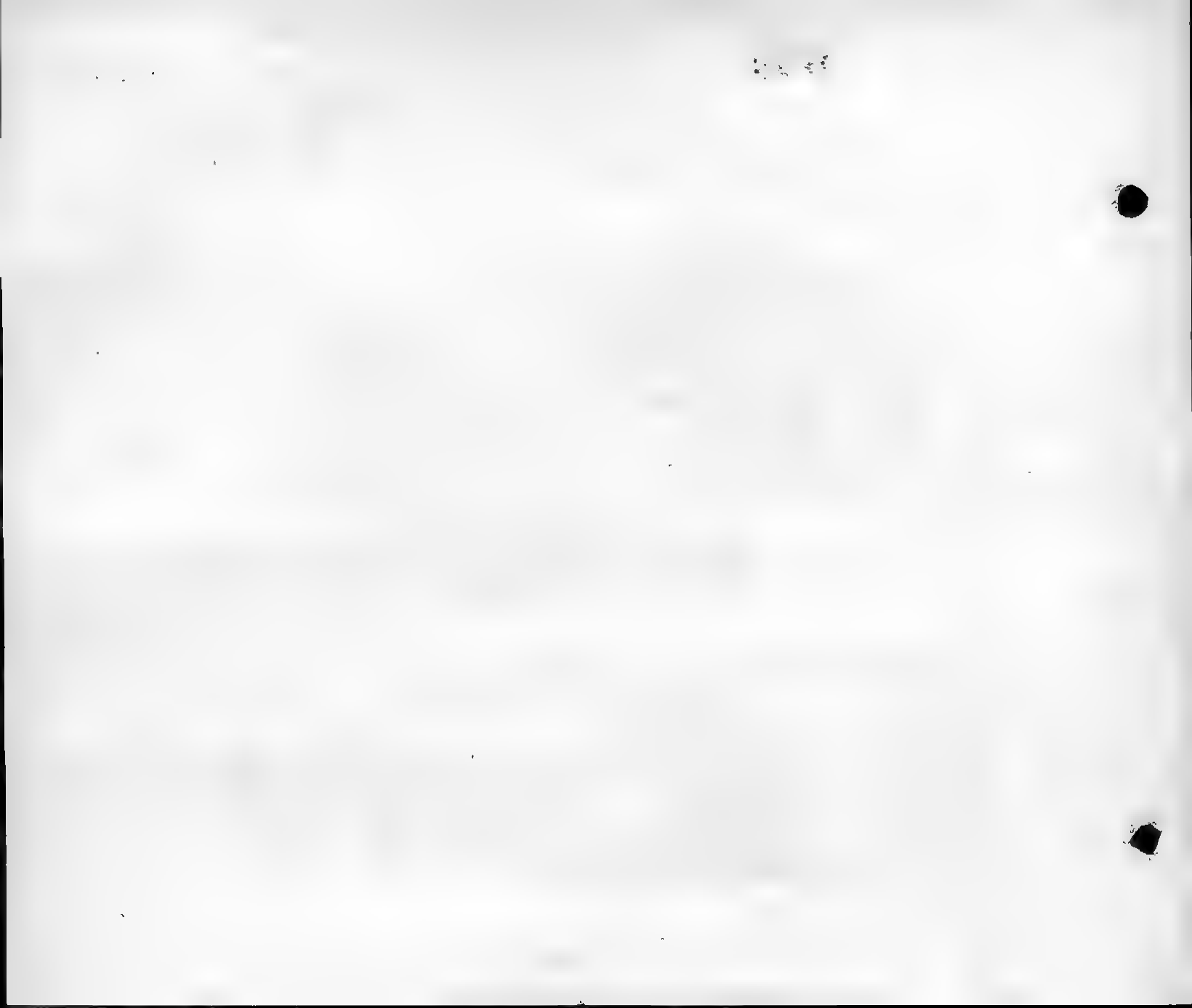
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shady Nook Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 359 Oaklea Village e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma Catherine Leonard		4. DATE OF DEATH Feb. 19, 1961	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 14, 1886	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		9. AGE (in years last birthday) 74 yrs	
11. BIRTHPLACE (Country & State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME ? Shauck		14. MOTHER'S MAIDEN NAME Saddle ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ? Shauck		16. SOCIAL SECURITY NO. Saddle ?	
17. INFORMANT Mr. Charles E. Gray, 359 Oaklea Village		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Uterus 174 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis C. V. Disease (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) Hemiplegia, left	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20a. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20b. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20d. PLACE OF INJURY (Home, farm, factory, street, office b.d.g., etc.) 20e. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 15, 1960 to Feb. 14, 1961 , that (I) (we) last saw the deceased alive on Feb. 11, 1961 , and that death occurred at 1 A.M. from the causes and on the date stated above.		22a. SIGNATURE D. C. MacLaughlin, M.D. 22b. DATE SIGNED 2/21/61 22c. PHYSICIAN'S NAME (Type) D. C. MacLaughlin, M.D. 22d. ADDRESS 4508 Edmondson Village, Balto. 29, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 22, 1961	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City, town or county) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus		25a. REC'D BY REGISTRAR DATE FEB 24 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. DATE FEB 24 '61	



1622

01692

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN TB 1yr3mtnl9dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Headville, Md.	
f. STREET ADDRESS Salem Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ada Middle - Last Lohn		4. DATE OF DEATH Month Feb Day 25 Year 1961	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1881
9. AGE (In years last birthday) 79		10. F UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	11. F UNDER 24 HRS Months 1 Days 1 Hours 1 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME BASEMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO 217-05-5397	
17. INFORMANT Records: SHRI G GROV. STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arteriosclerotic Cardio-Vascular disease associated 422 DUE TO heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Impending gangrene of the left leg & foot DUE TO arteriosclerotic changes in the peripheral arteries blood vessels & incapacity of the arterial circulation. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 8, 1960 , to Feb. 25, 1961 , that (I) (we) last saw the deceased alive on Feb. 25, 1961 and that death occurred at 10 P.M. , from the causes and on the date stated above			
22a. SIGNATURE Blanca Gomez		22b. DATE SIGNED Feb 25 1961	
22c. PHYSICIAN'S NAME (Type) Blanca G. Gomez		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2-28-61	23c. NAME OF CEMETERY OR CREMATORY London PARK	23d. LOCATION (City, town, or county) (State) Baltimore Md
24. FUNERAL DIRECTOR'S SIGNATURE Geo. L. Schwab		25a. REC'D BY REGISTRAR FEB 28 '61	
25b. REGISTRAR'S SIGNATURE Arthur E. Hume		25c. ADDRESS 2101 Frederick Ave.	



TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
1623 CERTIFICATE OF DEATH											
01603											
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY 1-14					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAWN				c. LENGTH OF STAY IN 1b 12 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X WOODLAWN					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1738 GORDON AVE						d. STREET ADDRESS 1738 GORDON AVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES A. MARLING						4. DATE OF DEATH FEB. 19, 1961					
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 18, 1908		9. AGE (In years last birthday) 53 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICK LAYER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ERNEST A. MARLING						14. MOTHER'S MAIDEN NAME MARTHA NIXON					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 218-10-7261		17. INFORMANT Address MRS RUTH BRUCE, 1738 GORDON AVE					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DISSECTING ANEURYSM - AORTA DUE TO ARTERIOSCLEROTIC CV DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 2 YRS DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 12 HRS.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) this hospital attended the deceased from 2-1 19 60 to 2-19 19 61 , that (I) was last saw the deceased alive on 2-18 19 61 , and that death occurred on 2-19 19 61 at 4:50 P. M., from the causes and on the date stated above.											
22a. SIGNATURE John F. Schaefer				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/20/61					
22c. PHYSICIAN'S NAME (Type) JOHN F. SCHAEFER MD				22d. ADDRESS 401 RANDOM RD. BALTO. 29-MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/24/61		23c. NAME OF CEMETERY OR CREMATORY LOUDON PK. CEMT.				23d. LOCATION (City, town, or county) (State) BALTO, MD			
24. FUNERAL DIRECTOR'S SIGNATURE WITZKE F.D.R. 4101 EDMONDSON						25a. REC'D BY REGISTRAR 2/21/61		25b. REGISTRAR'S SIGNATURE WITZKE F.D.R.			

TO HOSPITAL

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in _____ the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

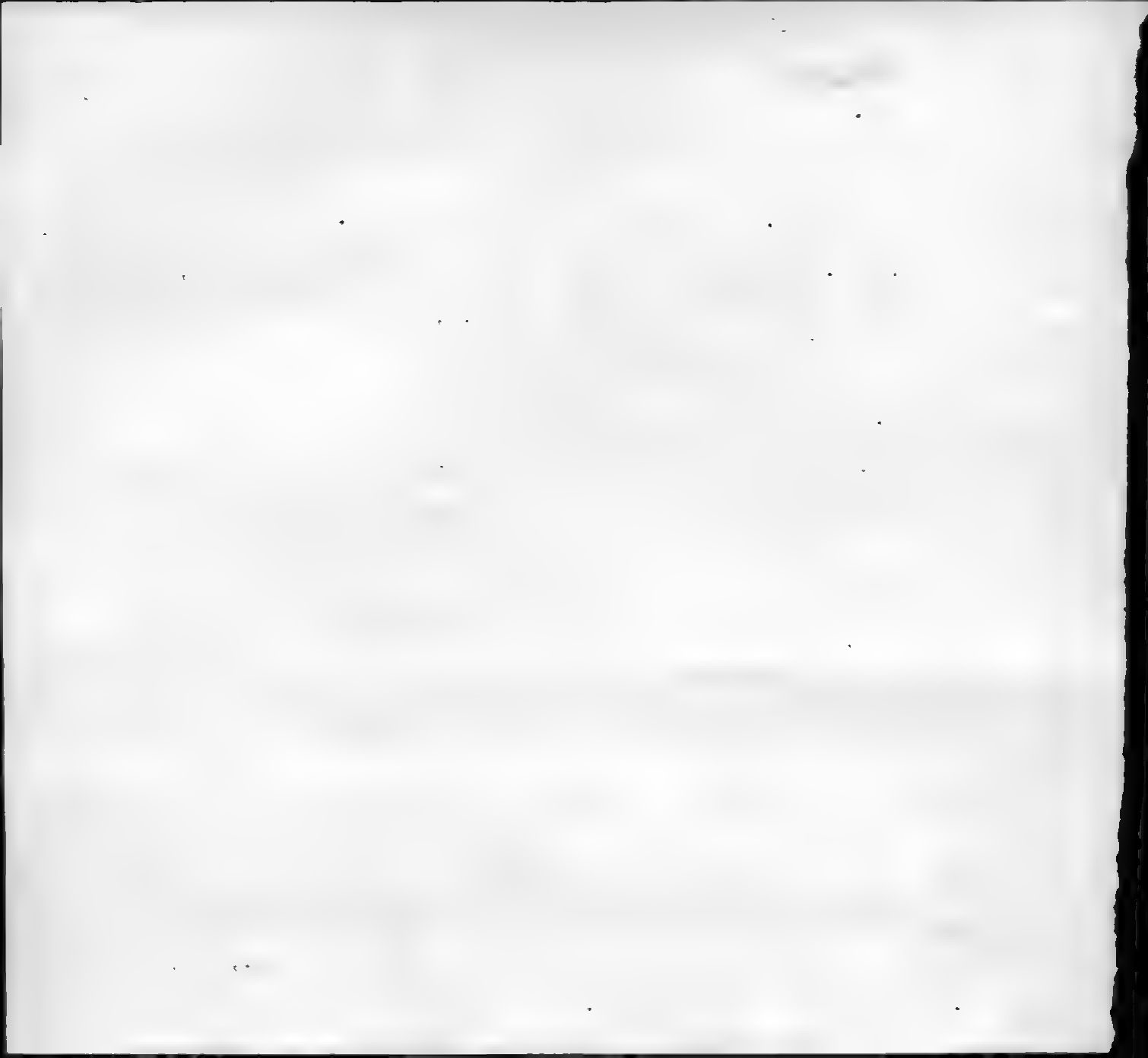
CERTIFICATE OF DEATH

1624

01604

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex #21			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Essex #21				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 315 Worton Rd.				f. STREET ADDRESS 315 Worton Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MARY I. MATHERS Middle Last 				4. DATE OF DEATH Month February Day 13 Year 19 61				
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8 DATE OF BIRTH August 27, 1902		9. AGE (In years last birthday) 58 yrs	IF UNDER 1 YEAR Months Days Hours Min 	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Retired		11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles F. Wagner				14. MOTHER'S MAIDEN NAME Anna Stumpf				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO. 214-22-2870		17. INFORMANT Marlene Becker		Address Same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 157X IMMEDIATE CAUSE (a) metastatic Carcinoma of pancreas DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic heart dis Coronary atherosclerosis							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1/12 to 2/13 , 19 61 , that (I) (we) last saw the deceased alive on 2/12 19 61 , and that death occurred at 6 P.M. from the causes and on the date stated above								
22a SIGNATURE J. Blutt				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED		
22c PHYSICIAN'S NAME (Type) J. BLUTT, M.D.				22d ADDRESS 424 Eastern Ave Essex, Md				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 2/16/61		23c NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d LOCATION (City, town, or county) (State) Baltimore Co., Maryland		
24 FUNERAL DIRECTOR'S SIGNATURE John A. Pruzanski				25a REC'D BY REGISTRAR 14 '61		25b. REGISTRAR'S SIGNATURE Arthur L. House		

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

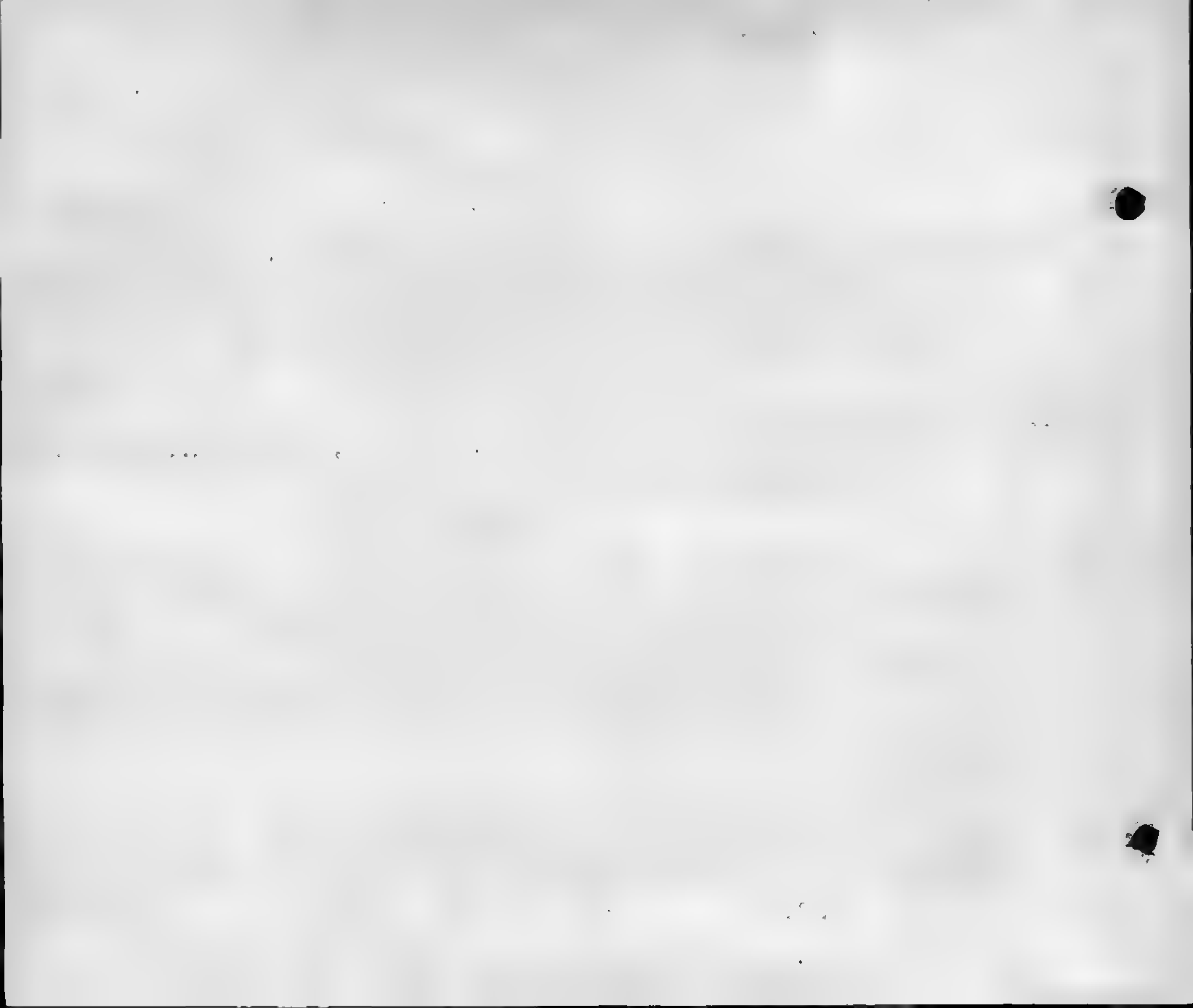
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FOR STATE
HEALTH DEPT.

1. If necessary, give this certificate to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN 1b <u>2 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>939 RADCLIFFE RD</u>					2. USUAL RESIDENCE (Where deceased lived, if institution. Resident or boarder, or lodger) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> d. STREET ADDRESS <u>939 RADCLIFFE RD</u>				
3. NAME OF DECEASED (Type or print) <u>THOMAS A. McCLOSKEY</u>					4. DATE OF DEATH Month <u>FEB</u> Day <u>19</u> Year <u>1961</u>				
5. SEX <u>M</u>					6. COLOR OR RACE <u>W</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>AUG. 23 1885</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>				
11. BIRTHPLACE (State or foreign country) <u>PENN.</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>JAMES McCLOSKEY</u>					14. MOTHER'S MAIDEN NAME <u>unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u>					16. SOCIAL SECURITY NO. <u>James B. McCloskey, Corbett Rd., Monkton, Md</u>				
17. INFORMANT <u>James B. McCloskey, Corbett Rd., Monkton, Md</u>					Address <u>Monkton, Md</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO (b) <u>ARTERIO SCLEROTIC CEREBROVASCULAR DISEASE</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u></u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <u>William A. Pillsbury</u>									
ASSISTANT MEDICAL EXAMINER <u></u>									
DEPUTY MEDICAL EXAMINER <u>2060 YORK RD Timonium Md.</u>									
Address (Street, city, town, or country)									
DATE SIGNED <u>2/19/61</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									
22b. DATE THEREOF <u>Feb. 21, 1961</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>									
22d. LOCATION (City, town, or country) <u>Baltimore Maryland</u>									
23. FUNERAL DIRECTOR <u>William Cook, Inc. - Towson</u>									
ADDRESS <u>1050 York Road</u>									
24a. REC'D BY REGISTRAR <u>FEB 23 '61</u>									
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

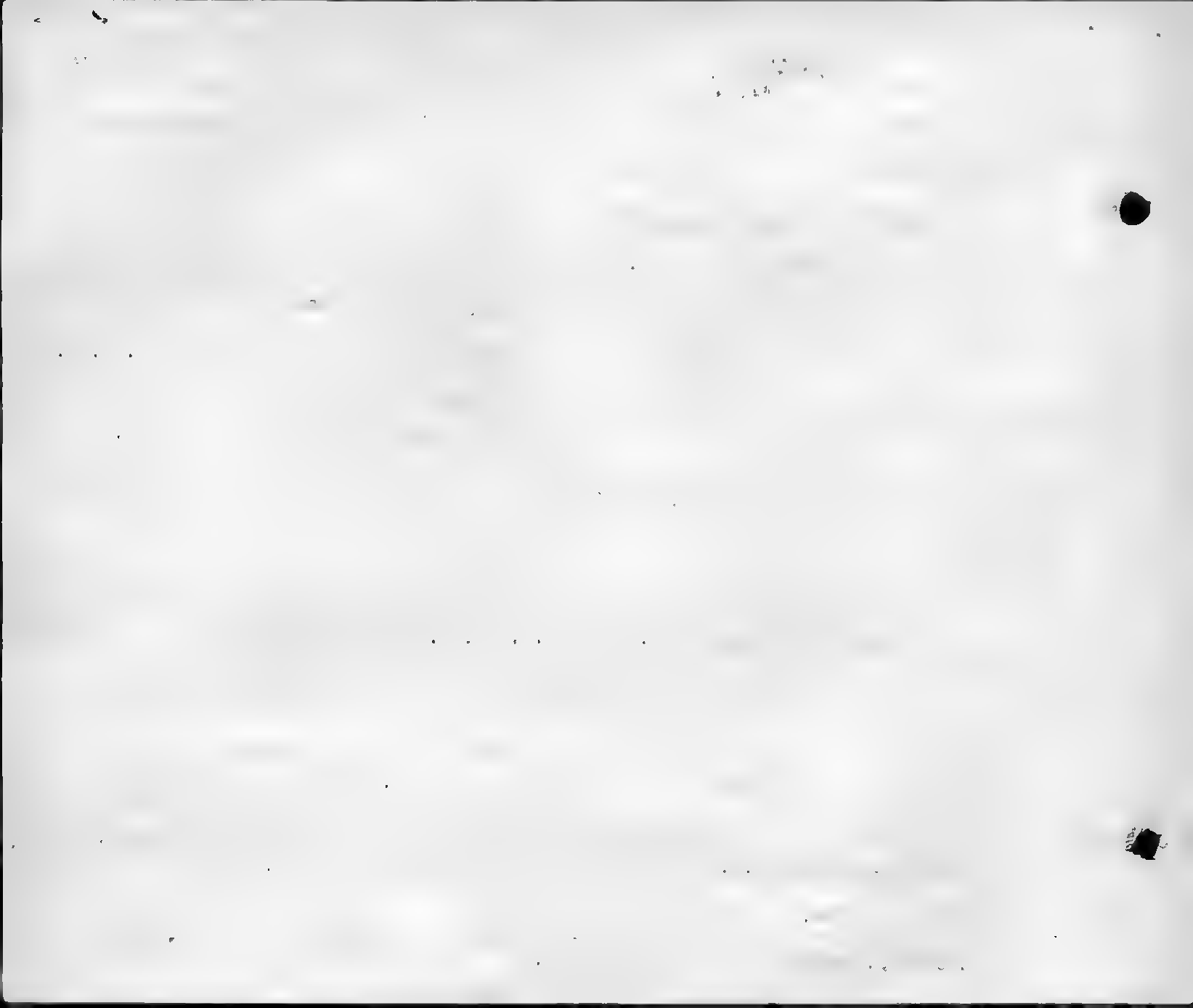
1626

CERTIFICATE OF DEATH

01606

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>36 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>153 Meadow Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>JAMES F. McNALLY</u>				4. DATE OF DEATH Month <u>February</u> Day <u>8</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 3, 1891</u>		9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ohne McNally</u>				14. MOTHER'S MAIDEN NAME <u>Bridgett Connelly</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year of discharge) <u>Yes WW I</u>				16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT Address <u>Clinical Records, VAH, Baltimore 18, Md. Fort Howard Division</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>24 Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1. Diabetes Mellitus - 8 Yrs. Duration. A.S.H. D. Duration, Unknown</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 3, 1961</u> to <u>February 8, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>2/8/61</u> at <u>4:05</u> p.m., and that death occurred at <u> </u> p.m., from the causes and on the date stated above.									
22a. SIGNATURE <u>Thomas F. Crahan</u> 22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. CRAHAN, M.D.</u>				22b. ADDRESS <u>Clinical Records, VAH, Baltimore 18, Md. Fort Howard Division</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Feb. 11, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Goncz</u>				25a. REC'D BY REGISTRAR <u>FEB 16 '61</u>		25b. REGISTRAR'S SIGNATURE <u>C. R. S. P. P.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1627

CERTIFICATE OF DEATH

Reg. Dist. No.

01607

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Florida</i> b. COUNTY <i>Orange</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Monkton</i>		c. LENGTH OF STAY IN 1b <i>55 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>JM Pence Road</i>		d. STREET ADDRESS <i>1775 Alameda Road</i>	
3. NAME OF DECEASED (Type or print) <i>Charlotte First Middle Last Arnold McNeil</i>		4. DATE OF DEATH <i>February 25 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>1 April 1888</i>
9. AGE (In years last birthday) <i>72</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George William Evans</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte Arnold COWAN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>none</i>	
17. INFORMANT <i>Mrs. Donald Pearce</i>		Address <i>Monkton, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular accident</i> DUE TO (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>3 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3 February 61</i> to <i>25 February 61</i> , that I last saw the deceased alive on <i>24 February 61</i> , and that death occurred at <i>2:30 P</i> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>Cochesville</i> DATE SIGNED <i>25 February 1961</i> ACTUAL SIGNATURE <i>Walter T. Kees</i> M.D. <i>Maryland</i> PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-28-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. James</i>	22d. LOCATION (City, town, or county) (State) <i>Monkton, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Brooks Funeral Service, Towson 4, Md.</i>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DATE *FEB 28 1961*

Walter T. Kees



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22B Film 4281 2/23/61 mb

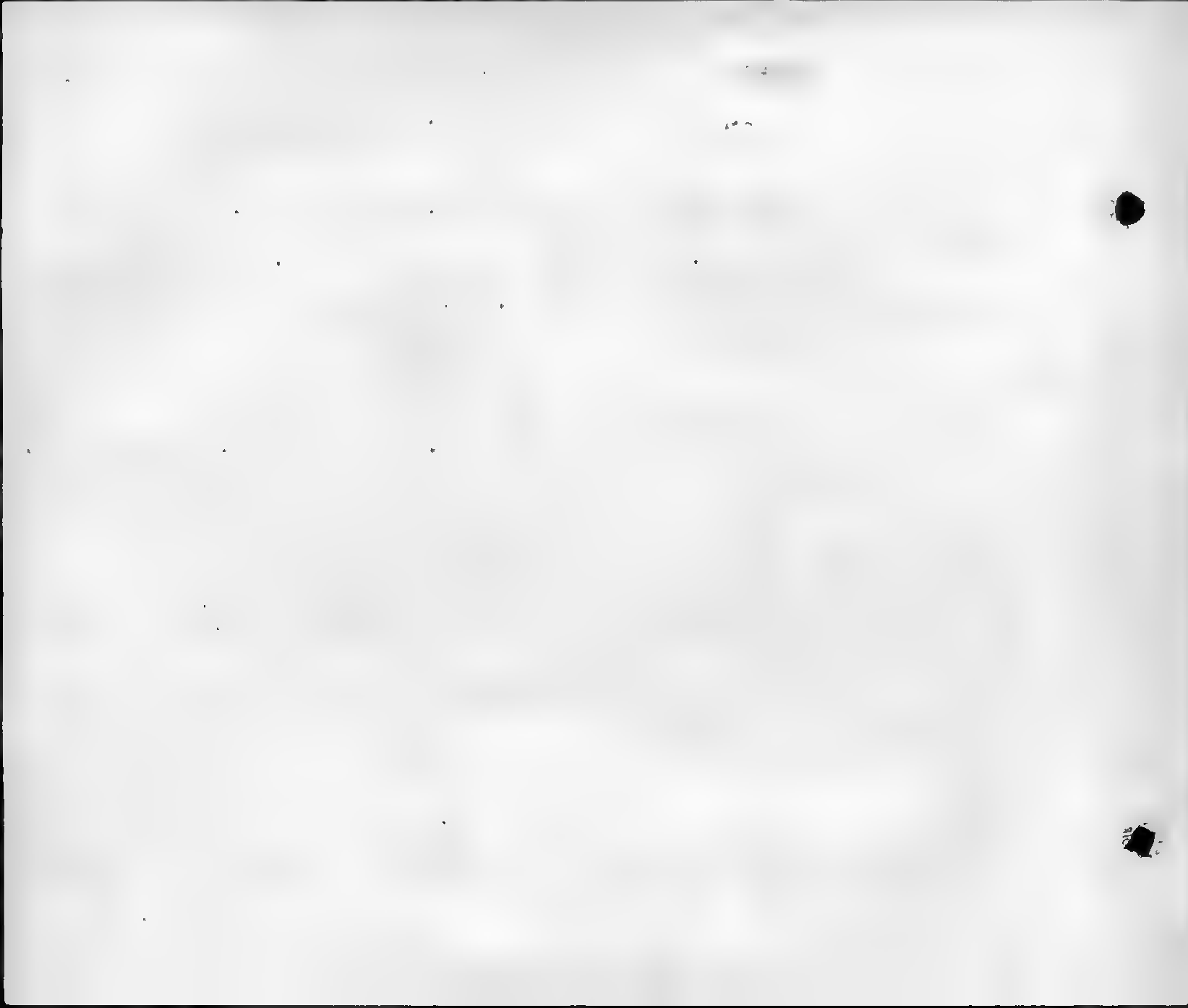
CERTIFICATE OF DEATH

Reg. Dist. No.

01608

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Rest Home		d. STREET ADDRESS 1914 W. Baltimore St.	
3. NAME OF DECEASED (Type or print) Herman H. A. Meiser		4. DATE OF DEATH Feb. 14, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1869
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR: Months 2 Days 19 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Herman Meiser		14. MOTHER'S MAIDEN NAME Margaret Schneider	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Carroll H. Meiser		Address 1914 W. Baltimore St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degenerative Heart Disease DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Incompetent + Gangrene Left Rt. Indolent Ulcer Left Rt.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 2/14/61 , 19 61 , to 2/14/61 , 19 61 , that I last saw the deceased alive on 2/14/61 , 19 61 , and that death occurred at 9:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1303 Frederick Rd. Catonsville 28 Md.	
ACTUAL SIGNATURE W. E. Mac Grath M.D.		DATE SIGNED 2/16/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 17, 1961	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Baltimore 7, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Cole		24a. REC'D BY REGISTRAR DATE FEB 17 '61	
ADDRESS 1913 W. Baltimore St.		24b. REGISTRAR'S SIGNATURE Charles S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1629

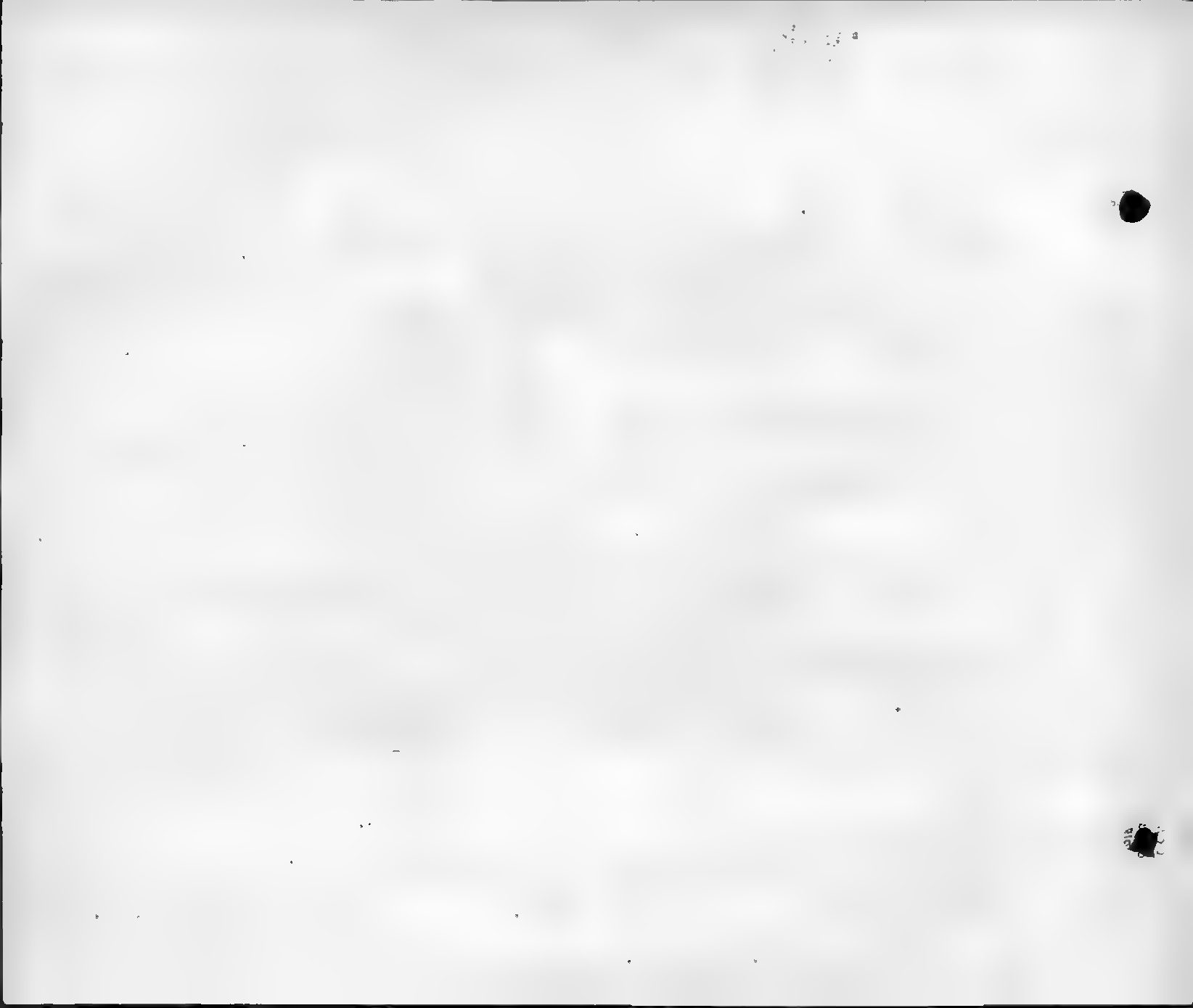
CERTIFICATE OF DEATH

Reg. Dist. No. 01634

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville			
c. LENGTH OF STAY IN 1b 20 yrs.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Broadway Rd.				d. STREET ADDRESS Broadway Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle MELSE, SR. Last MELSE, SR.				4. DATE OF DEATH Month Feb. Day 2 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 26, 1884	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76		IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min. 76			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener				10b. KIND OF BUSINESS OR INDUSTRY Gardening		11. BIRTHPLACE (State or foreign country) Holland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Melse				14. MOTHER'S MAIDEN NAME Maetje Constant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218-14-9206		17. INFORMANT Address Mrs. Helen Melse, Broadway Rd., Lutherville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 157X DUE TO Ca. of head of pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ca. of head of pancreas DUE TO (c) Ca. of head of pancreas INTERVAL BETWEEN ONSET AND DEATH 4 mos. 1 yr. est.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. none				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
20f. (City or town) none				20g. (County) none		20h. (State) none	
21. I certify that I attended the deceased from 3-20-40 , 19____, to 2-2-61 , 19____, that I last saw the deceased alive on 1-10-61 , 19____, and that death occurred at 7:07 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 2-2-61							
ACTUAL SIGNATURE D. D. Caples				M. D. 6 Hanover Rd.			
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.				Reisterstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/6/61		22c. NAME OF CEMETERY OR CREMATORY Carroll Meth.		22d. LOCATION (City, town, or county) (State) Baltimore County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. York Rd. Towson 4, Md				ADDRESS Wm Cook-Towson, Inc. York Rd. Towson 4, Md		24a. REC'D BY REGISTRAR FEB 10 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1630

CERTIFICATE OF DEATH

Reg. Dist. No. 01610

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarm Rural				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural				e. STREET ADDRESS Glenarm, Maryland			
3. NAME OF DECEASED (Type or print) Sister M. Ruth				4. DATE OF DEATH February 4 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-30-1877	9. AGE (In years last birthday) 83 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Frank Merling				14. MOTHER'S MAIDEN NAME Mary Bachmann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address Sr. M. Henrica Villa Maria Glenarm, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 442 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerotic cardio- DUE TO (c) renal vascular disease.							INTERVAL BETWEEN ONSET AND DEATH 2 wks
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 1951 , to February 1961 , that I last saw the deceased alive on January 24, 1961 , and that death occurred at 6:30 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Charles F. O'Donnell MD				PHYSICIAN'S NAME (Type) Charles F. O'Donnell 7501 York Road Towson, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 2-6-61		22b. DATE THEREOF 2-6-61		22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.		22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NR. TOWSON, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Giles				24a. REC'D BY REGISTRAR DATE FEB 6 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01611

1631

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

8020 Hillendale Road Zone 4

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Md.

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

8020 Hillendale Rd.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

FREDERICK

Middle

W. MERTZ, SR.

Last

4. DATE OF DEATH

Feb. 23

Day

Year

19 61

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

2/12/1881

9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.)

80 yrs.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

ret-printer

10b. KIND OF BUSINESS OR INDUSTRY

Fleet-McKinley Inc.

11. BIRTHPLACE (County & State, or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Conrad Mertz

14. MOTHER'S MAIDEN NAME

Mary Essiview

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

213-01-9813

17. INFORMANT

Address

Zone 14

Frederick L. Mertz, Jr., 6307 Marietta Av

18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

DUPLICATE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUPLICATE

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 2/15, 1961, to 2/23, 1961, that (I) (we) last saw the deceased alive on 2/23, 1961, and that death occurred at 11:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Gordon Grau, M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

2/25/61

22d. ADDRESS

8523 Lech Raven Blvd, Balto. 4, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

2/27/61

23c. NAME OF CEMETERY OR CREMATORY

Gardens of Faith

23d. LOCATION (City, town or county)

Baltimore, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Charles H. Schimunek Funeral Home

3331 Rehms Lane

25a. REC'D BY REGISTRAR

FEB 28 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. House

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1632
CERTIFICATE OF DEATH

01612

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2620 Windsor Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>12620 Windsor Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. Joseph A. Miles</u>		4. DATE OF DEATH <u>February 13th 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1897</u>
9. AGE (in years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Machinist</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Miles</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>705-05-3494</u>		17. INFORMANT <u>Mrs. Christine Miles</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>Arteriosclerotic CVD.</u> Conditions, if any, which gave rise to immediate cause (b) <u>120-1</u> DUE TO <u>120-1</u> (c) <u>120-1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 min</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>120-1</u> p.m. <u>120-1</u>		20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not White</u> <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (If in hospital) attended the deceased from <u>January 19, 1961</u> to <u>2/13</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1/14/61</u> , 19 <u>61</u> , and that death occurred at <u>6:30</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold A. Grott</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Harold A. Grott</u> M.D.		22b. ADDRESS <u>8100 Harford Road Balto. 14, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/16/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		25a. REC'D BY REGISTRAR <u>FEB 14 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Turner</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1633

CERTIFICATE OF DEATH

01613

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN (b) <u>2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if not last one; Residence before admission) a. <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 17</u> d. STREET ADDRESS <u>2009 Westwood Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>LAWRENCE</u> Middle <u>M.</u> Last <u>MILLER</u>				4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 18, 1894</u>	
9. AGE (In years last birthday) <u>66</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Handler</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES P. MILLER</u>				14. MOTHER'S MAIDEN NAME <u>FRANCES LAWRENCE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <u>YES WW-1</u>				16. SOCIAL SECURITY NO. <u>CLIN REC VAH BALTO 18 MD-FT HOWARD DIVISION</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>THROMBOSIS OF LEFT MIDDLE CEREBRAL ARTERY WITH</u> <u>446X</u> <u>BRAIN INFARCT</u> <u>HYPERTENSION</u> (b) <u>DUE TO NEPHROSCLEROSIS</u> <u>Due to</u> (c) <u>ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>EDEMA OF THE LUNGS - Duration 24 Hours</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>3:25</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>MD</u> (this hospital) attended the deceased from <u>February 7, 1961</u> , to <u>February 9, 1961</u> , that <u>X</u> (we) last saw the deceased alive on <u>February 9, 1961</u> , and that death occurred at <u>3:25 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas F. Crahan</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2-10-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. CRAHAN, M. D.</u>				22d. ADDRESS <u>VAH Baltimore 18 Md - Ft Howard Division</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 14, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Holland Funeral Home</u>				25a. REC'D BY REGISTRAR <u>1631 Druid Hill Ave Baltimore 17 Md</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				DATE <u>FEB 14 '61</u>			

100

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

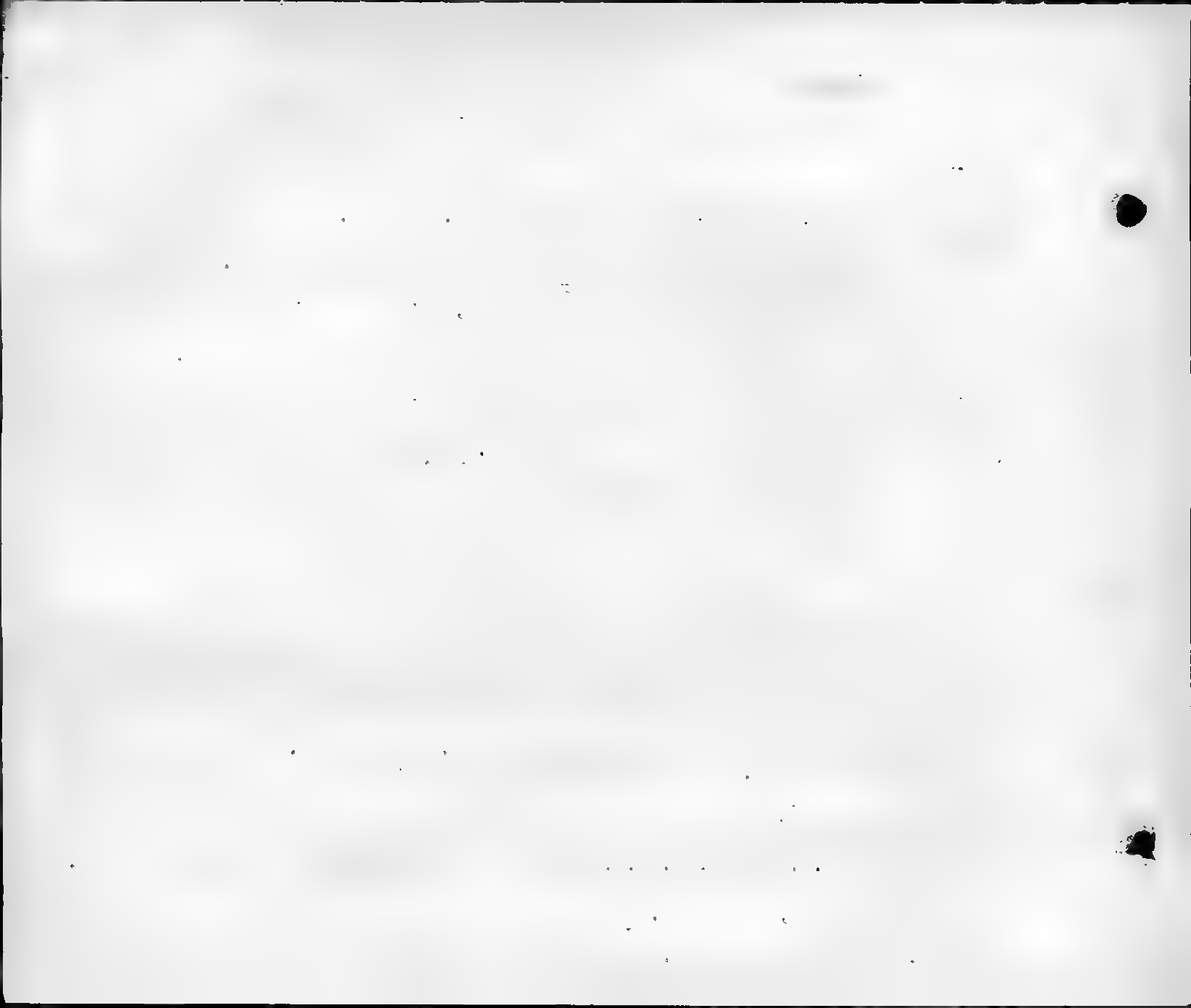
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 9 Film-231 2-16-61 et

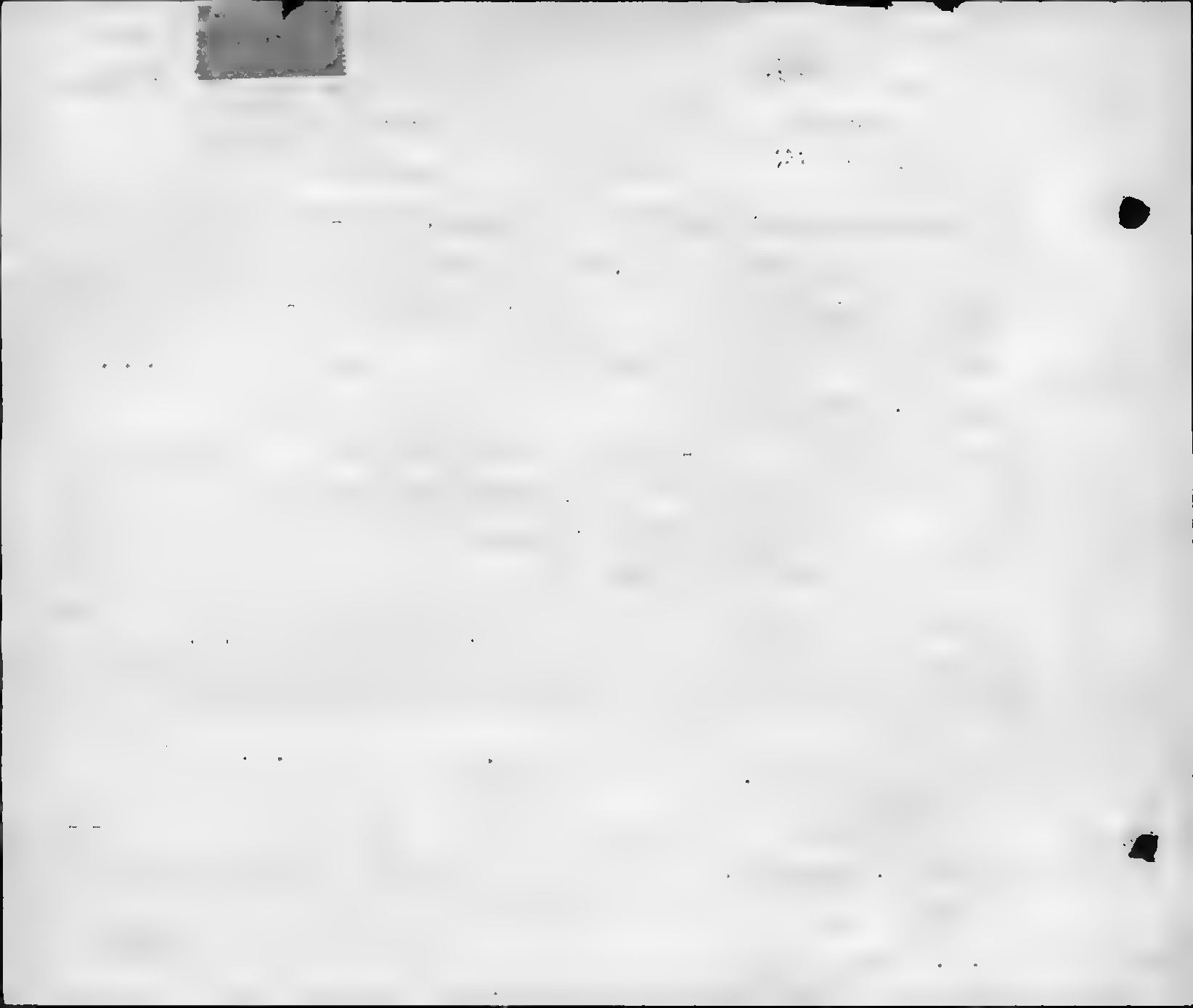
01614

1. PLACE OF DEATH a. COUNTY Baltimore 1634 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN lb RURAL and give nearest town) d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Presbyterian Home Towson		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 731 E. 20th St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary E Mills		4. DATE OF DEATH Feb. 8th 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1870
9. AGE (In years last birthday) 87 90rs		10. IF UNDER 1 YEAR 11 Months 4 Days 11 Hours 11 Min	11. IF UNDER 24 HRS
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Mills		14. MOTHER'S MAIDEN NAME Clara Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO Mrs T.E. Elliott	
17. INFORMANT Presbyterian Home		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO (b) 491X DUE TO (c) 491X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralysis Agitans			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Jan 1, 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7215 York Road, Baltimore 12, Md.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1958 to Feb. 8, 1961 , that (I) (we) first saw the deceased alive on Feb. 5, 1961 , and that death occurred at 7a M, from the causes and on the date stated above			
22a. SIGNATURE S.J. Venable, Jr. M.D.		22b. ADDRESS 7215 York Road, Baltimore 12, Md.	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 10, 1961	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Fitchell & Sons Inc.		25a. REC'D BY REGISTRAR FEB 14 '61	
ADDRESS 1900 Eutaw Place		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 5, MARYLAND											
1635 CERTIFICATE OF DEATH 01615											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Maryland b. COUNTY Roaches Lane c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 2, Box 96-A d. STREET ADDRESS Reisterstown							
3. NAME OF DECEASED (Type or print) CLYDE A. TWOOD MISTER				4. DATE OF DEATH February 5 19 61				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 28, 1927		9. AGE (in years last birthday) 33 yrs.		10. IF UNDER 1 YEAR: Months 33 Days 33 Hours 33 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver				10b. KIND OF BUSINESS OR INDUSTRY Cab Company				11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLYDE A. MISTER				14. MOTHER'S MAIDEN NAME EDNA MAY BOWEN				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Korean				16. SOCIAL SECURITY NO. 220-22-3642				17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GLIOMA OF THE RIGHT TEMPORAL-PARIETAL REGION											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ACUTE BRONCHITIS ACUTE PURULENT CYSTITIS EDEMA OF THE LUNGS											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e)											
Operation-Removal of glioma. December, 1960, Md. Gen. Hospital, Balto. Md.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER;)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (County) (State)	
21. I certify that 10 (this hospital) attended the deceased from Feb. 2, 1961 to Feb. 5, 1961 , that 10 (we) last saw the deceased alive on Feb. 5, 1961 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Thomas F. Crahan				22b. DATE SIGNED 2-6-61				22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2-9-61				23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens Finksburg, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons Inc				25a. REC'D BY REGISTRAR FEB 8 '61				25b. REGISTRAR'S SIGNATURE Arthur L. Frank			
North & Pennsylvania Avenues, Baltimore, Md.											

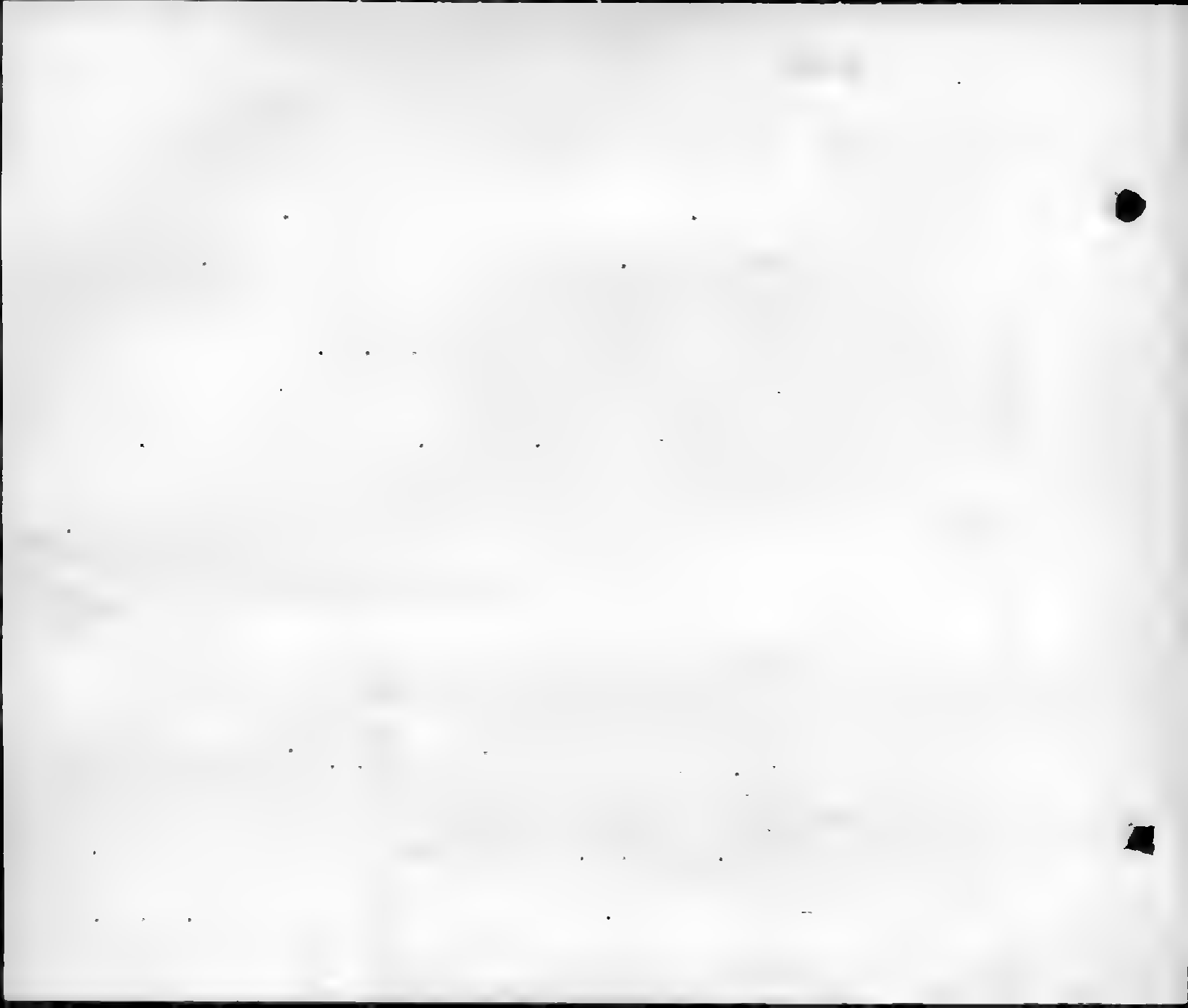


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VR A15 (4)
15M 9/59

1636
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
01616

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4219 Necker Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Eleanor A. Mohr		4. DATE OF DEATH Month Day Year Feb. 22, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1914
9. AGE (In years lost birthday) yrs. 46		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles Dieter		14. MOTHER'S MAIDEN NAME Margaret Kraft	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 273-32-4034	
17. INFORMANT Mr. George J. Mohr		Address 4219 Necker Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Carcinomatosis 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of rectum DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 10, 1960, to Feb. 22, 1961, that (I) (we) last saw the deceased alive on Feb. 22, 1961, and that death occurred at 2:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Theodore E. Evans M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Theodore E. Evans, M.D.		22d. ADDRESS 9660 Belair Road - 6 - Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-25-1961	
23c. NAME OF CEMETERY OR CREMATORY St. Joseph's		23d. LOCATION (City, town, or county) (State) Fullerton, Balto. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 24 '61	
Sassaqui Funeral Home 7401 Belair Rd.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. See pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

163 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01617

1. PLACE OF DEATH
a. COUNTY Balto. MARYLAND
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Baltimore
c. LENGTH OF STAY IN b 10 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1024 F. Lagtree Drive

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE Md. b. COUNTY Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto 7
d. STREET ADDRESS 5515 Wilman Ave

3. NAME OF DECEASED (Type or print) LOUIS McLOFSKY
4. DATE OF DEATH Feb 11 1961
5. SEX male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH Feb 11 1901
9. AGE (In years last birthday) 65 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator 10b. KIND OF BUSINESS OR INDUSTRY Electric Shop 11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James McLoFSKY 14. MOTHER'S MAIDEN NAME Anna

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 212-07-4807 17. INFORMANT Clara McLoFSKY (Wife) Address Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Angina Pectoris
DUE TO (b) Coronary Arteriosclerosis
DUE TO (c) Longstanding Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. None
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None
20c. TIME OF INJURY Month, Day, Year None
20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐ None
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

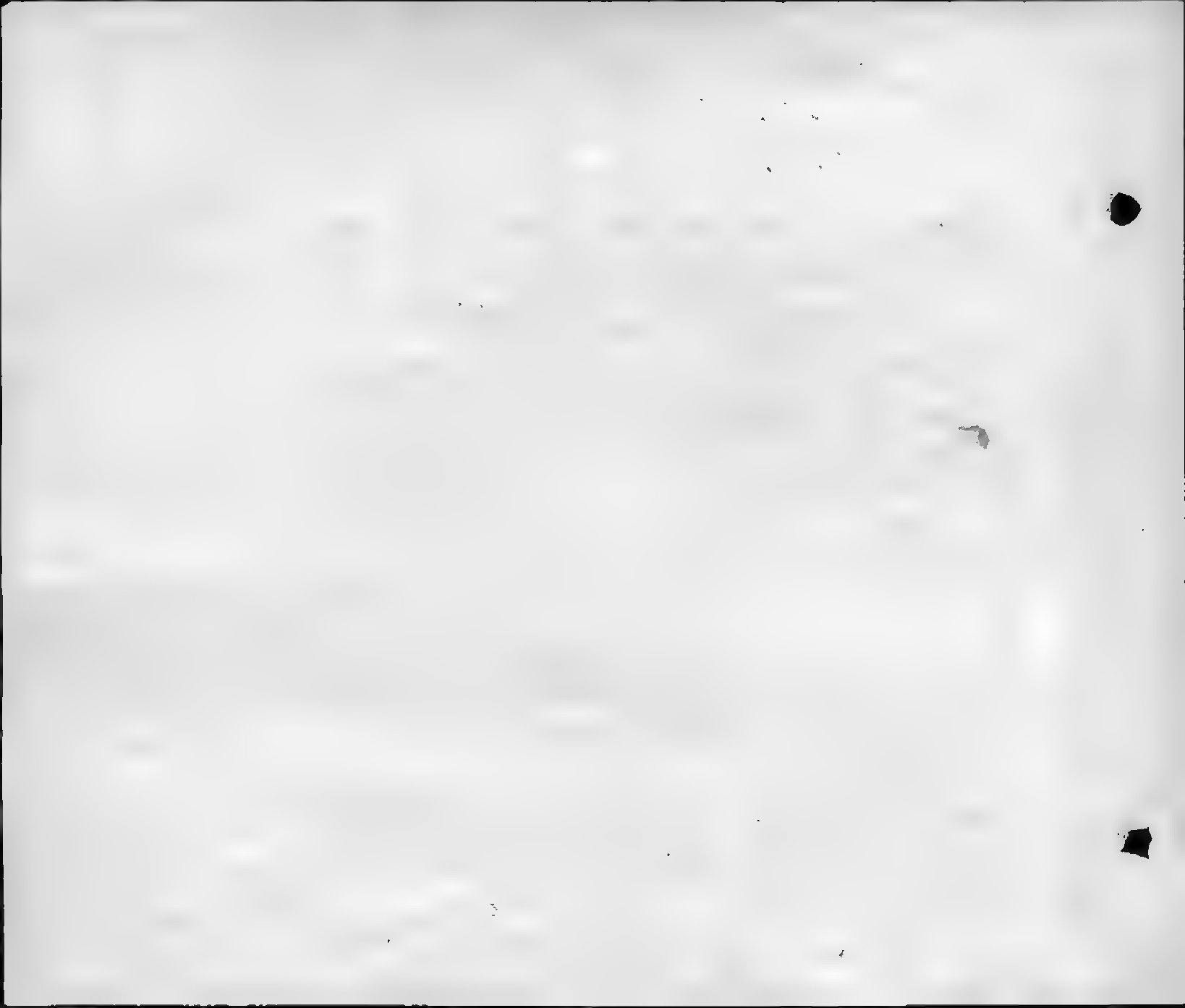
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 2-11-61
Address (Street, city, town, or county)

ACTUAL SIGNATURE D. D. Cayles EXAMINER'S NAME (Type) D. D. CAYLES

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2-13-61 22c. NAME OF CEMETERY OR CREMATORY United Hebrew 22d. LOCATION (City, town, or country) (State) Balto Md

23. FUNERAL DIRECTOR Jack Lewin ADDRESS 2100 Eutaw Place 24a. REC'D BY REG. STRAR 1461 24b. REG. STRAR'S SIGNATURE Samuel S. Thomas

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **01618****1638**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ida Gertrude Monaghan				4. DATE OF DEATH Month Day Year February 9 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 16, 1888	
9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At. Home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore,	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Mullineaux				14. MOTHER'S MAIDEN NAME Scheible			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 218-34-0706		INFORMANT Address Donald Monaghan - Dogwood and Ridge Rds. 7	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic suppurative cerebrovascular disease 443X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Obesity INTERVAL BETWEEN ONSET AND DEATH 2 yrs +							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 1960 to Feb 9, 1961 , that I last saw the deceased alive on Feb 9, 1961 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) BALTIMORE							
ACTUAL SIGNATURE John A. Nesbitt Jr.				M.D. 1118 St Paul St 2-10-61			
PHYSICIAN'S NAME (Type) JOHN A. NESBITT JR.				Baltimore 2 Ind.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-61		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTIONS SIGNATURE Ellsworth Armacost				24a. REC'D BY REGISTRAR FEB 24 '61		24b. REGISTRAR'S SIGNATURE Cirino L. House	
25. Ellsworth Armacost - 4600 Liberty Hghts. Ave.							

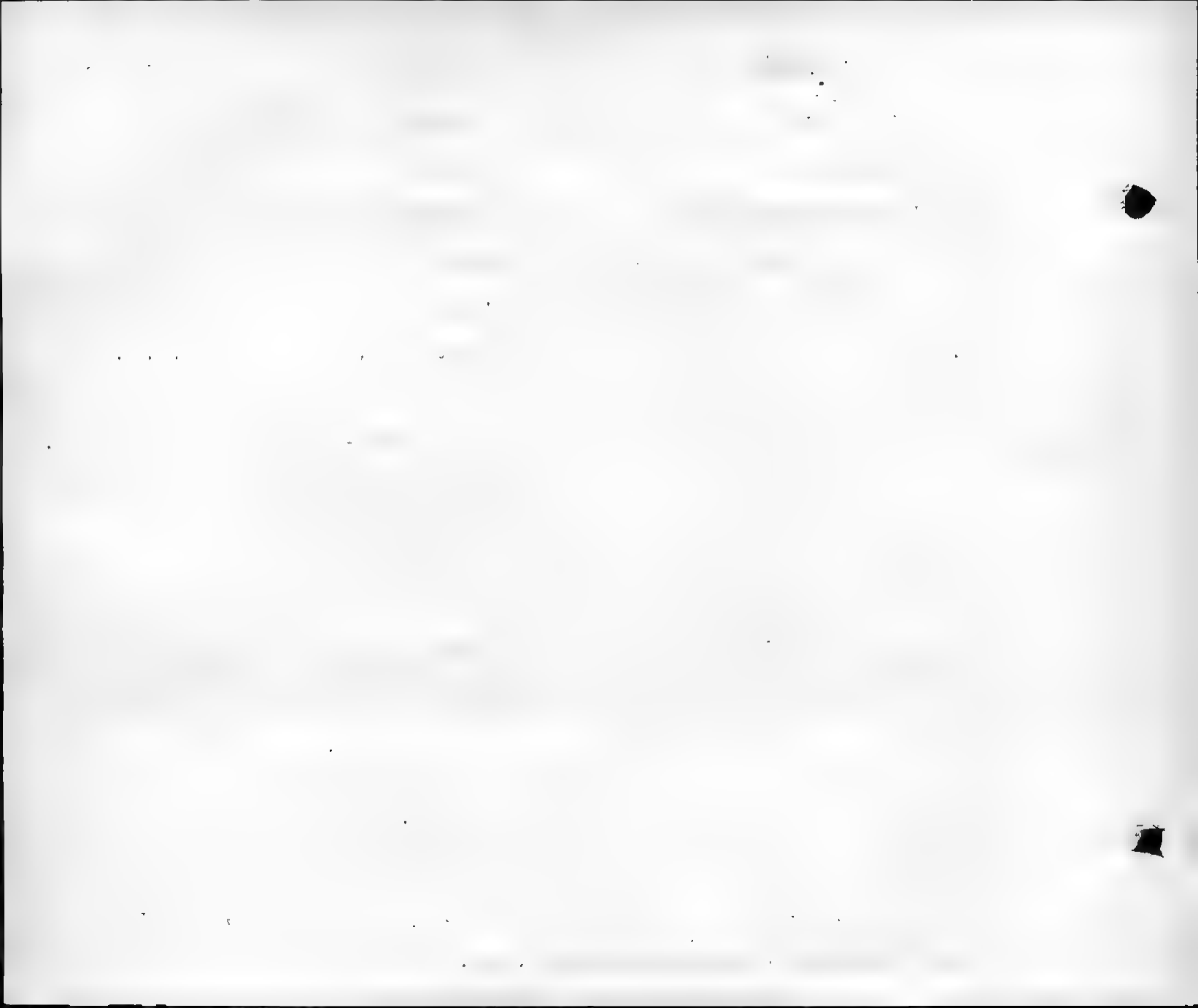
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



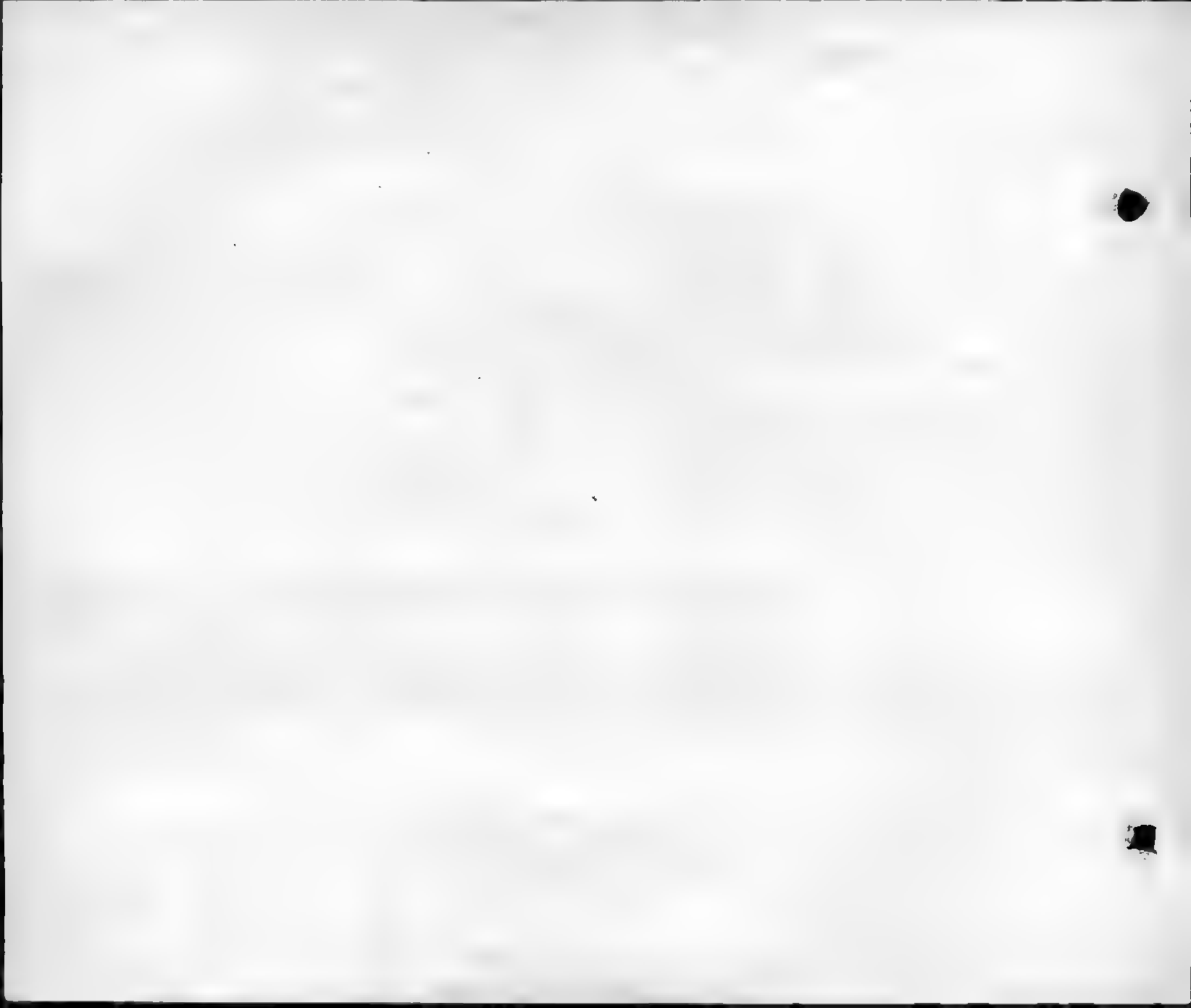
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1639

01619

1. PLACE OF DEATH a. COUNTY <u>Baltes.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltes.</u>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Baltes 7.</u>		c. LENGTH OF STAY IN 1b <u>7 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltes 7.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3403 Ripple Road</u>				d. STREET ADDRESS <u>13403 Ripple Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lucy</u>				4. DATE OF DEATH <u>Feb. 15 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 5, 1863</u>	
9. AGE (In years last birthday) <u>98</u> yrs		IF UNDER 1 YEAR: Months <u>1</u> Days <u>10</u> Hours <u></u> Min <u></u>		IF UNDER 24 HRS: Months <u></u> Days <u></u> Hours <u></u> Min <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Hamlin, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Lawrence</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Black</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO <u></u>		17. INFORMANT <u>Mrs Virginia Fairbairn</u> Address <u>Baltes 7 3403 Ripple Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction acute</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis, Generalized</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 Hours</u> <u>15 years</u> <u>20 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY: Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 3, 1959</u> to <u>FEB 15, 1961</u> , that (I) was last saw the deceased alive on <u>FEB 15, 1961</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Benjamin Berdawn</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>BENJAMIN BERDAWN</u>				22d. ADDRESS <u>7809 LIBERTY ROAD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>2/15/61</u>		<u>Oakland Cemetery</u>		<u>Oakland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Erving Byers</u>				ADDRESS <u>8728 Liberty Rd</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 20 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

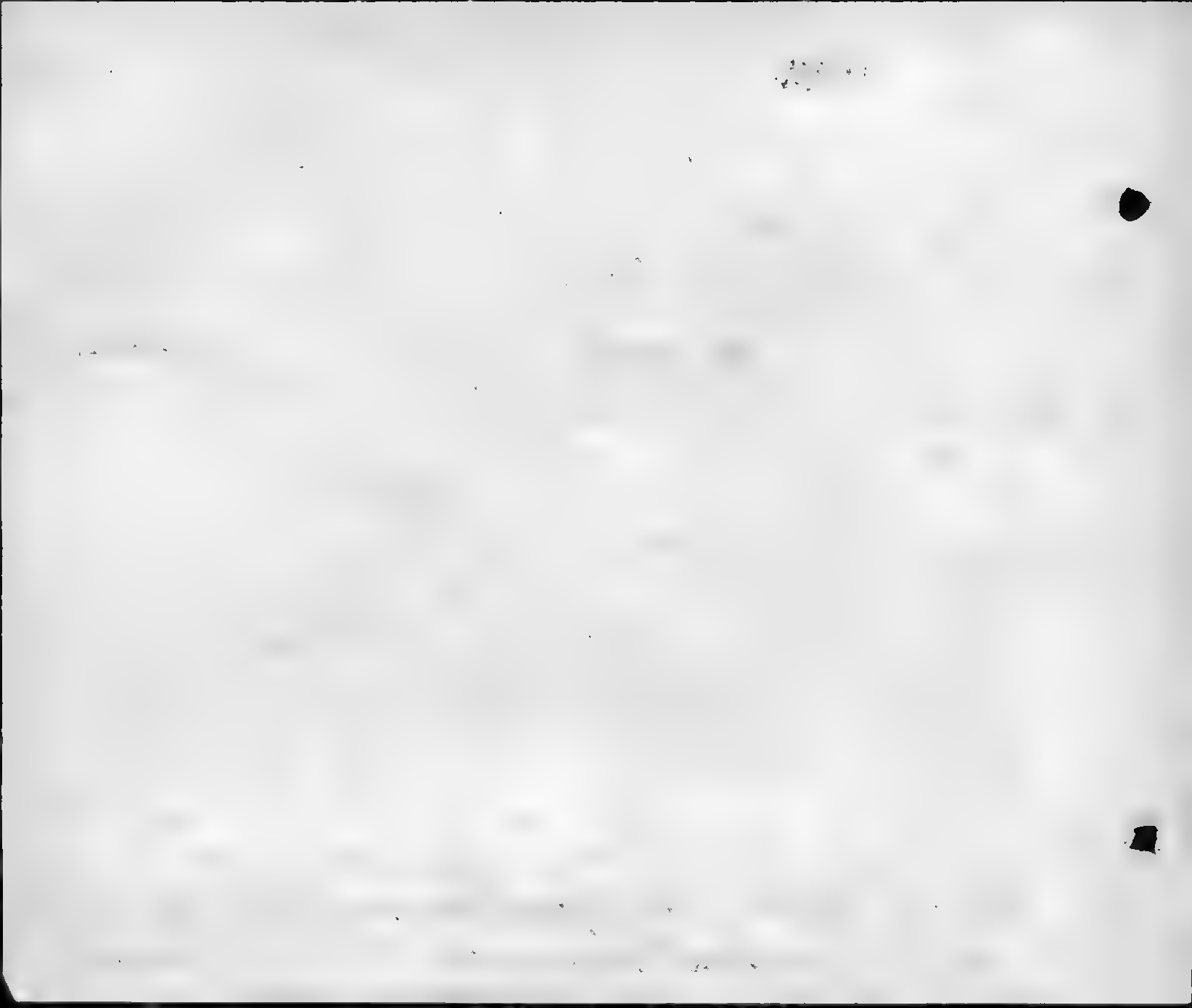
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1640

01620 ✓
 201-1

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b 19 yrs 278 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore city Maryland d. STREET ADDRESS 105 North Monroe St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First M. Middle MULLIGAN Last MULLIGAN		4. DATE OF DEATH Month 2 Day 12 Year 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-1875	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR: Months 8 Days 5 IF UNDER 24 HRS: Hours 5 Min. 5		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house maid		10b. KIND OF BUSINESS OR INDUSTRY for family		11. BIRTHPLACE (County & State, or foreign country) Ireland			
13. FATHER'S NAME MARTIN MULLIGAN		14. MOTHER'S MAIDEN NAME CATHERINE LAVIN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ✓		16. SOCIAL SECURITY NO ✓		17. INFORMANT Records: Spring Grove State Hospital Address Spring Grove State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE DUE TO (b) GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 1. ARTERIOSCLEROTIC VALVULAR DAMAGE, 2. RIGHT BUNDLE BRANCH BLOCK							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) BLOCK					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from JULY 1, 1959 to FEB. 12, 1961 that (I) (we) last saw the deceased alive on FEB. 12, 1961 , and that death occurred at 4:45 AM from the causes and on the date stated above.							
22a. SIGNATURE Patrick K. Y. Yip		M.D. PATRICK K. Y. YIP		22b. DATE SIGNED 2/12/61			
22c. PHYSICIAN'S NAME (Type) PATRICK K. Y. YIP		22d. ADDRESS SPRING GROVE STATE HOSPITAL, BALTO, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/15/61		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.			
23d. LOCATION (City, town or county) 4300 Old Frederick Rd.		(State) MD.		23e. REC'D BY REGISTRAR FEB 14 '61			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Cowan, son		ADDRESS 98 Hollins St.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

VR A15 (4)
 15M 9/60

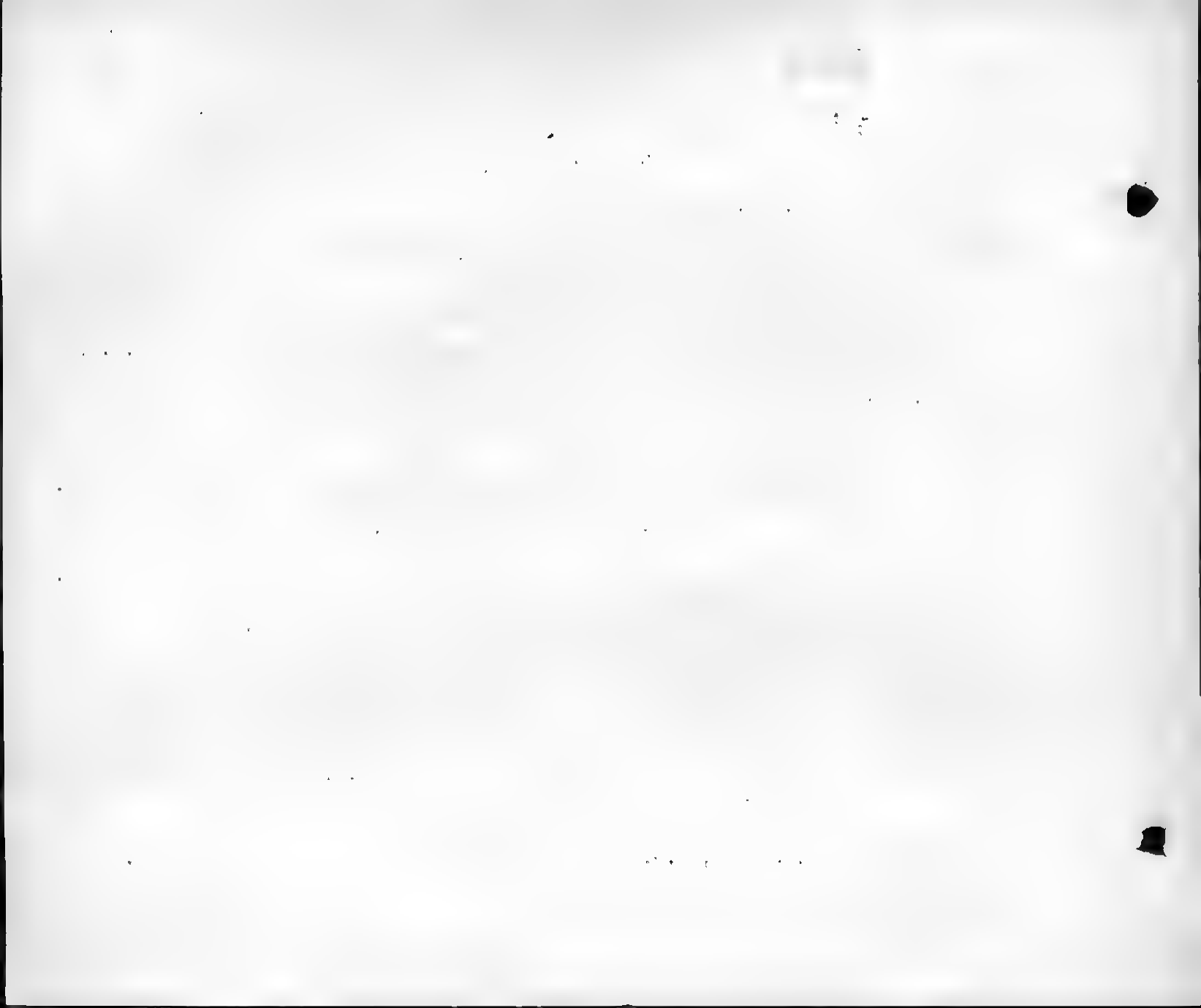


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Annes</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. LENGTH OF STAY IN 1b <u>41 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood St. Tr. School</u>		e. STREET ADDRESS <u>none</u>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Mullikin</u> Last <u>Mullikin</u>		4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>19 61</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/26/05</u>
9 AGE (In years last birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR Months <u>55</u> Days <u>55</u> Hours <u>55</u> Min. <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Mullikin (deceased)</u>		14. MOTHER'S MAIDEN NAME <u>Mary Plummer - Queenstown, Maryland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Rosewood Records</u>		Address <u>Rosewood Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis, generalized, with complicating</u> DUE TO (c) <u>hypertension and obesity.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>8 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Recurrent grand mal seizures (epilepsy) idiopathic - 50 yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>(Anatomical Board case)</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/21</u> 19 <u>61</u> to <u>2/9/</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>2/9</u> 19 <u>61</u> , and that death occurred at <u>7:30</u> on the causes and on the date stated above.			
22a. SIGNATURE <u>Harry G. Butler</u>		22b. DATE SIGNED <u>2/9/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>		22d. ADDRESS <u>Rosewood Lane, Owings Mills, Md.</u>	
23a. BURIAL OR CREMATION REMOVAL (Specify) <u>2-10-61</u>		23b. DATE THEREOF <u>2-10-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cemetery Board</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Howell</u>		25a. REC'D BY REGISTRAR <u>Arthur S. House</u>	
ADDRESS <u>Pikes & 9th</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	
DATE <u>FEB 17 '61</u>			



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

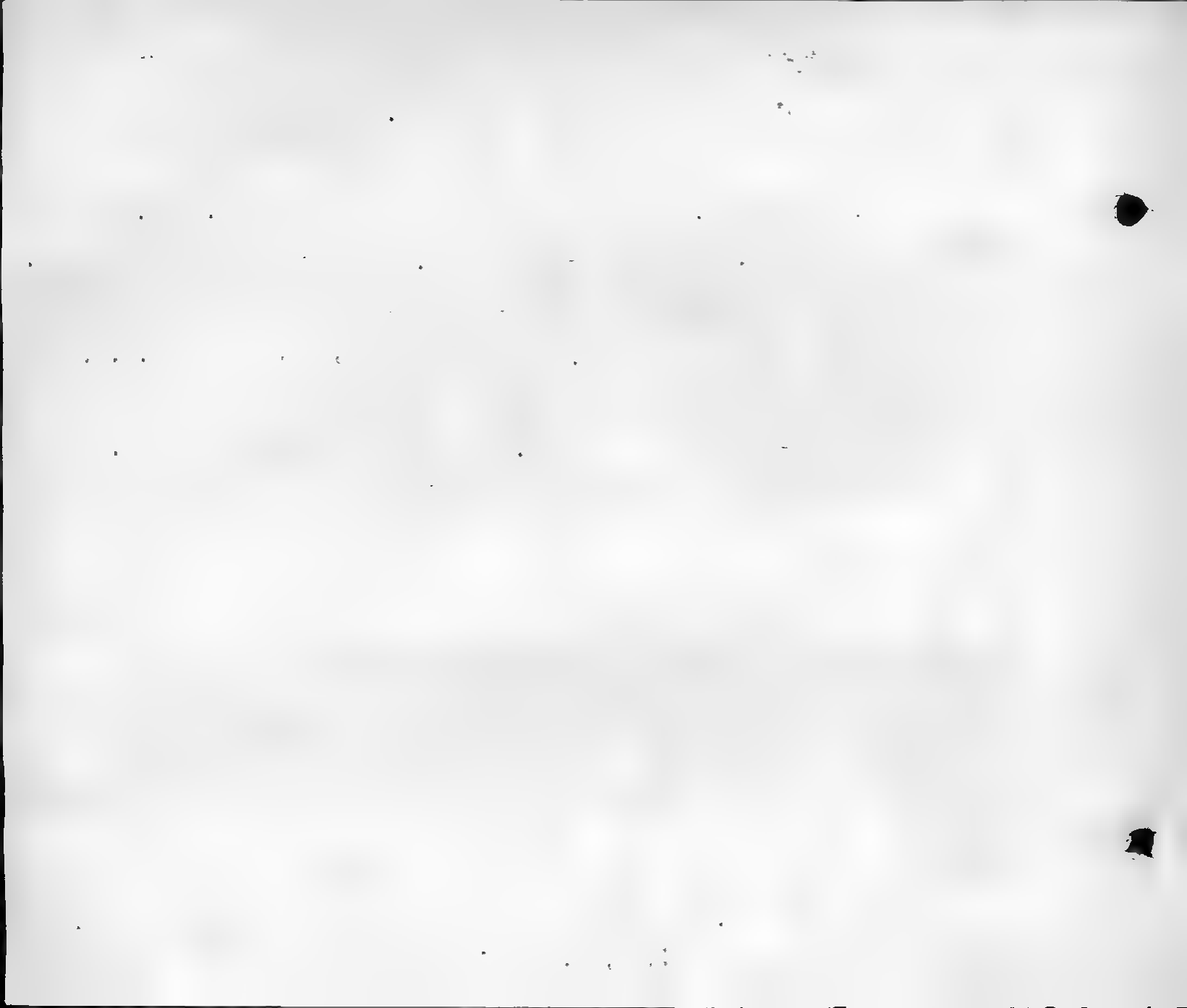
1642 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01622

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b <u>X</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2132 Jasmine Rd. # 22</u>			d. STREET ADDRESS <u>2132 Jasmine Rd. # 22.</u>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>CHARLES W. NOCKEMAN - NACKEMANN.</u>			4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>19 61.</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27 1911</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chauffeur.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Ernest Nockeman</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u> </u>			17. INFORMANT <u>A. Christina Nockeman</u> Address <u>Same.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>A-S-C-V Disease</u> (c) <u> </u> DUE TO cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>No one</u>			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2/11/61</u>	
EXAMINER'S NAME (Type) <u>M. B. Davis M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/13/61.</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		22d. LOCATION (City, town, or county) (State) <u>Trump Mill Rd. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Geiler</u>		ADDRESS <u>901 S. Conkling St. Balto., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 14 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>					

THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNO. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



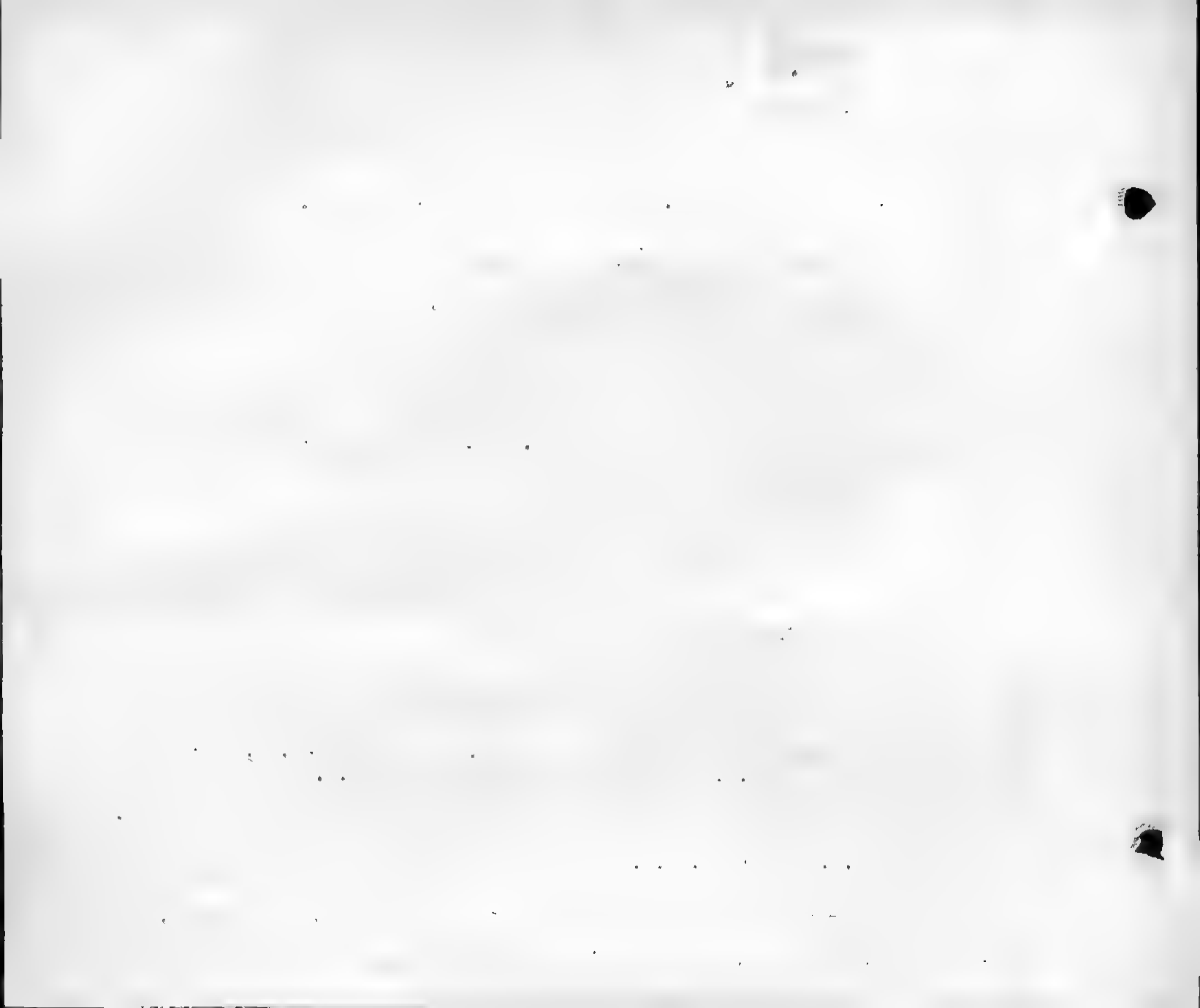
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1643 CERTIFICATE OF DEATH 01623

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Presbyterian Home of Md.				d. STREET ADDRESS 4613 Roland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Shelley Last Neely				4. DATE OF DEATH Month February Day 5 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31, 1877		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 83 Days 0 Hours 0 Min 0	IF UNDER 24 HRS. Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Amos Shelley			14. MOTHER'S MAIDEN NAME Anna Mary Herr				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ✓		16. SOCIAL SECURITY NO. ✓		17. INFORMANT Mrs. T.E. Elliott		Address Presbyterian Home	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia 733X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Cord Bladder with chronic pyelonephritis (c) Severe Osteoporosis with multiple collapsed vertebra						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Jan Day 1 Year 1958 Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from Jan 1, 1958 to Feb. 5, 1961 , that (I) (we) saw the deceased alive on Feb. 1, 1961 , and that death occurred at 7:30 p.m. on the causes and on the date stated above.							
22a. SIGNATURE S.J. Venable, Jr. M.D.				22b. DATE Feb. 6, 1961		22c. PHYSICIAN'S NAME (Type) S.J. Venable, Jr. M.D.	
22d. ADDRESS 7215 York Road				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-9-61		23c. NAME OF CEMETERY OR CREMATORY Westminister Presbyterian Church, Mifflintown, Penna.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place				25a. REC'D BY REGISTRAR FEB 8 '61		25b. REGISTRAR'S SIGNATURE Arthur L. House	



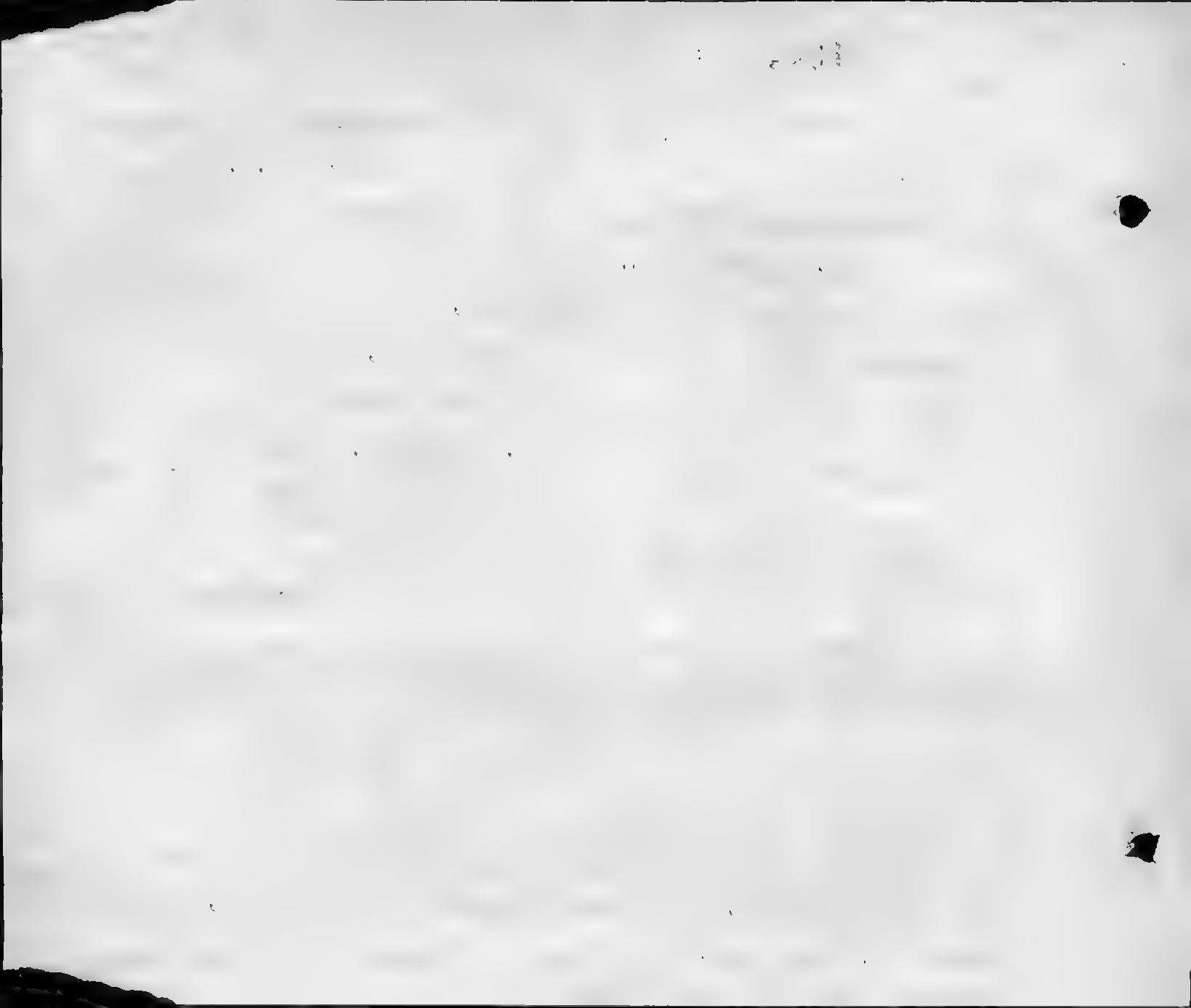
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TO HOSE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1644
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01624

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix P.O.</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>Jarrattsville Pike</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Jarrattsville Pike</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Louisa A. Neiberlein</u>		4. DATE OF DEATH <u>February 21 19 61</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 5, 1880</u>	
9. AGE (In years if UNDER 1 YEAR; last birthday) <u>80</u> yrs		10. MONTHS <u>8</u> DAYS <u>19</u> HOURS <u>61</u> MIN.	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>		12. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Julius Popp</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs. Charles J. Miller</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Virus Lobar Pneumonia - Right</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>same</u> (a), stating the underlying cause last. DJE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Nephritis, Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOT BY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year <u>Feb. 17, 1961</u> Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 17, 1961</u> to <u>Feb. 21, 1961</u> ; that (I) (we) last saw the deceased alive on <u>Feb. 21, 1961</u> , and that death occurred at <u>3:30</u> M., from the causes and on the date stated above.		22a. SIGNATURE <u>Theodore G. de Quevedo</u> M.D.	
22b. PHYSICIAN'S NAME (Type) <u>Theodore G. de Quevedo</u>		22c. ADDRESS <u>Cockeysville - Maryland</u>	
22d. DATE SIGNED		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/24/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>FEB 24 '61</u>	
ADDRESS <u>5305 Harford Road #14</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>	

VR A15 (4)
15M 9/60



1645

CERTIFICATE OF DEATH

Reg. Dist. No. 01625

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE Maryland c. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, 4 Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, 4, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1215 Limekiln Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First SAMUEL Middle A Last NEIDICH		4. DATE OF DEATH Month Feb. Day 11 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1875
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Inventor & Mnfr.		10b. KIND OF BUSINESS OR INDUSTRY Office Equipmnt.	
11 BIRTHPLACE (State or foreign country) Carlisle, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Dr. George Neidich		14. MOTHER'S MAIDEN NAME Mary Elliott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO INFORMANT Address Geo. G. Neidich, Medford Lakes, N.J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) Terminal Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Atherosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c):			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 60 , to Feb. 10 , 19 61 , that I last saw the deceased alive on Feb. 10 , 19 61 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2/10/61 ACTUAL SIGNATURE Walter B. Buck M.D. 18 E. Egan St PHYSICIAN'S NAME (Type) WALTER B. BUCK Balt - 2			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Feb. 14, 1961	
22c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		22d. LOCATION (City, town, or county) (State) Burlington, N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc.		24a. REC'D BY REGISTRAR FEB 14 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. **01626**

1646

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5614 Carville Ave</u>				d. STREET ADDRESS <u>442 N. Patterson Park Ave</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Thomas O'Leary</u>				4. DATE OF DEATH Month Day Year <u>Feb. 17th 1961</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 1st 1890</u>			
9. AGE (In years last birthday) <u>70</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman Sanitation Dept Baltimore City</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>					
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Thomas Joseph O'Leary</u>				14. MOTHER'S MAIDEN NAME <u>Johanna Finn</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes WWI</u>				16. SOCIAL SECURITY NO. <u>214-14-5011</u>					
17. INFORMANT <u>Mrs Theresa O'Leary</u>				Address <u>442 N. Patterson Park Ave</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>Dec 10th</u> , 19 <u>60</u> , to <u>Feb 17</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb 17</u> , 19 <u>61</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>John O'Leary</u> M.D. PHYSICIAN'S NAME (Type) _____									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Feb. 20, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Batl. Natl. Cem.</u>			
22d. LOCATION (City, town, or county) (State) <u>Batl. Ave Balt. Md.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>George A. Weber Jr.</u>				ADDRESS <u>5614 Carville Ave</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 17 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>Living & Thomas</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01627

1647

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO-RURAL ROSEDALE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto Rural Rosedale	
c. LENGTH OF STAY IN 1b 2yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1212 PRIMROSE		d. STREET ADDRESS 1212 PRIMROSE	
e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LUDWIG JOSEPH PAZDERA		4. DATE OF DEATH Month Day Year Feb 14 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 5 1906
9. AGE (In years last birthday) 54 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dental tech		10b. KIND OF BUSINESS OR INDUSTRY Dental Prothesis	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME FRANK		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-1972	
17. INFORMANT Marie L. PAZDERA		Address 1212 Primrose Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardiovascular Dis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Immed unk			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John C Hyle		DATE SIGNED 2-14-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-17-61	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Philip F. Croach		ADDRESS 1211 Chesaco Ave.	
24a. REC'D BY REGISTRAR FEB 20 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
1648
1648
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
01628

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 21yr5mthldy		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1914 Harlem Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louis Middle J. Last Perry				4. DATE OF DEATH Month Feb. Day 18, Year 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 11, 1883	
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ship builder				10b. KIND OF BUSINESS OR INDUSTRY railroad		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown John Perry				14. MOTHER'S MAIDEN NAME Unknown Ella Perry ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO (If yes, give war or dates of service) Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Branchopneumonia DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO Pneumonia DUE TO Pneumonia							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Interfered secretion							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 2 19 61 to 2/18 19 61 , that (I) (we) last saw the deceased alive on 2/18 19 61 , and that death occurred at 2:45 M. from the causes and on the date stated above							
22a. SIGNATURE Stella W. W. W.				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) STELLA W. W. W.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/21/61		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J.T. Stansbury				ADDRESS 6411 Windsor Mill Rd.		25a. REC'D BY REGISTRAR DATE FEB 21 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

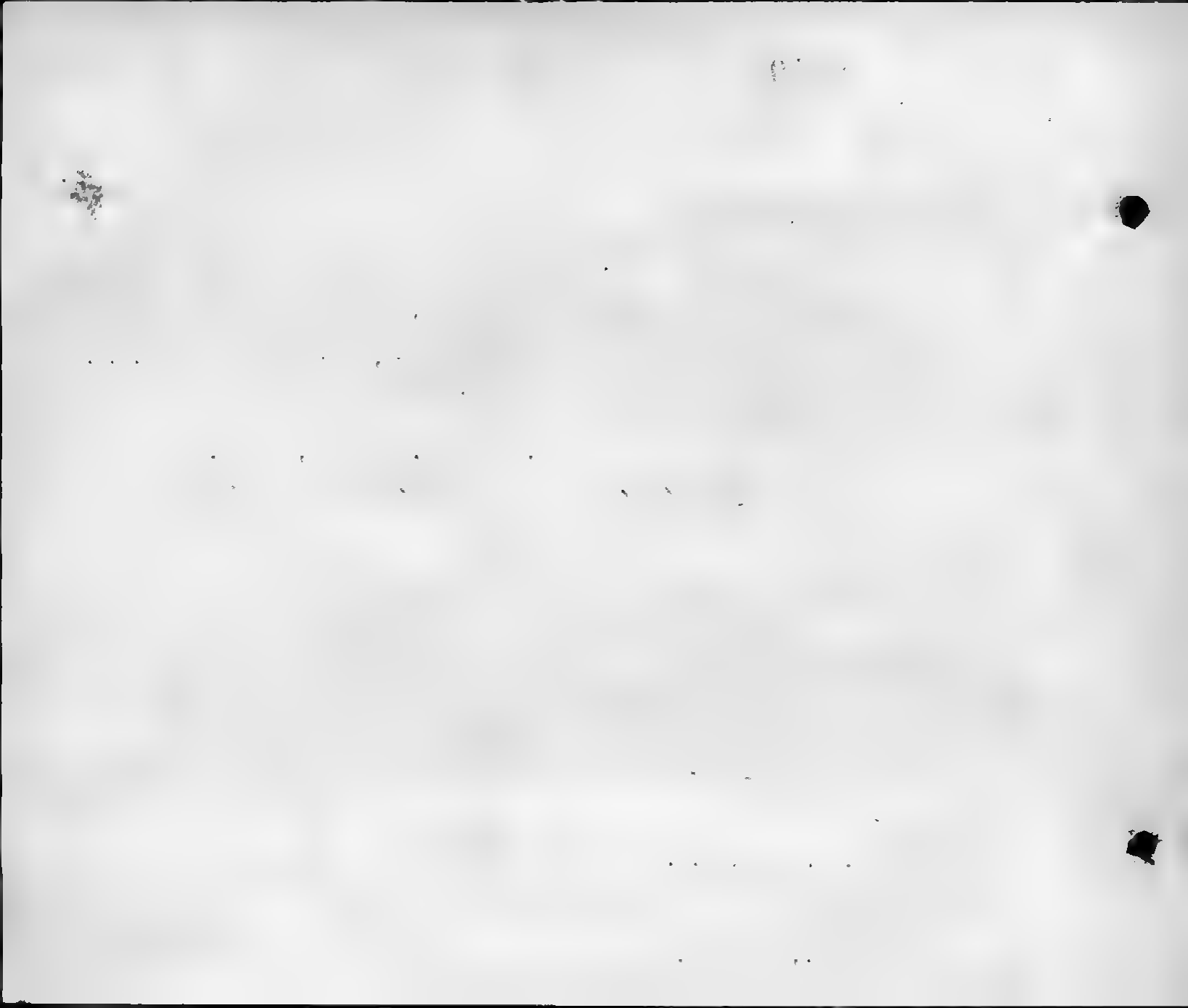
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1649

01629

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson 4</u>		c. LENGTH OF STAY IN 1b <u>Towson 4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Towson Convalescent Home</u> <u>301 West Chesapeake Avenue</u>		d. STREET ADDRESS <u>33 Cedar Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Sophia</u> First <u>G.</u> Middle <u>Poehlman</u> Last		4. DATE OF DEATH <u>February 14</u> 19 <u>61</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 10, 1876</u> 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9. AGE (In years if UNDER 1 YEAR, if UNDER 24 HRS., last birthday) Months Days Hours Min. <u>84</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Carl Gerhold</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs. George I. Poehlman, 202 St. Agnes Lane</u>		Address <u>Zone 7</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Recompensative Cardio Vascular Disease</u> <u>Atherosclerosis</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1950</u> to <u>Feb 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 14, 1961</u> , and that death occurred at <u>5:20 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Laurence C. Post</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>L. C. Post, M.D.</u>		22d. ADDRESS <u>6804 York Road, Baltimore 12</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-17-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore County</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 17 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hous</u>			



CERTIFICATE OF DEATH

1650

MARYLAND
17100

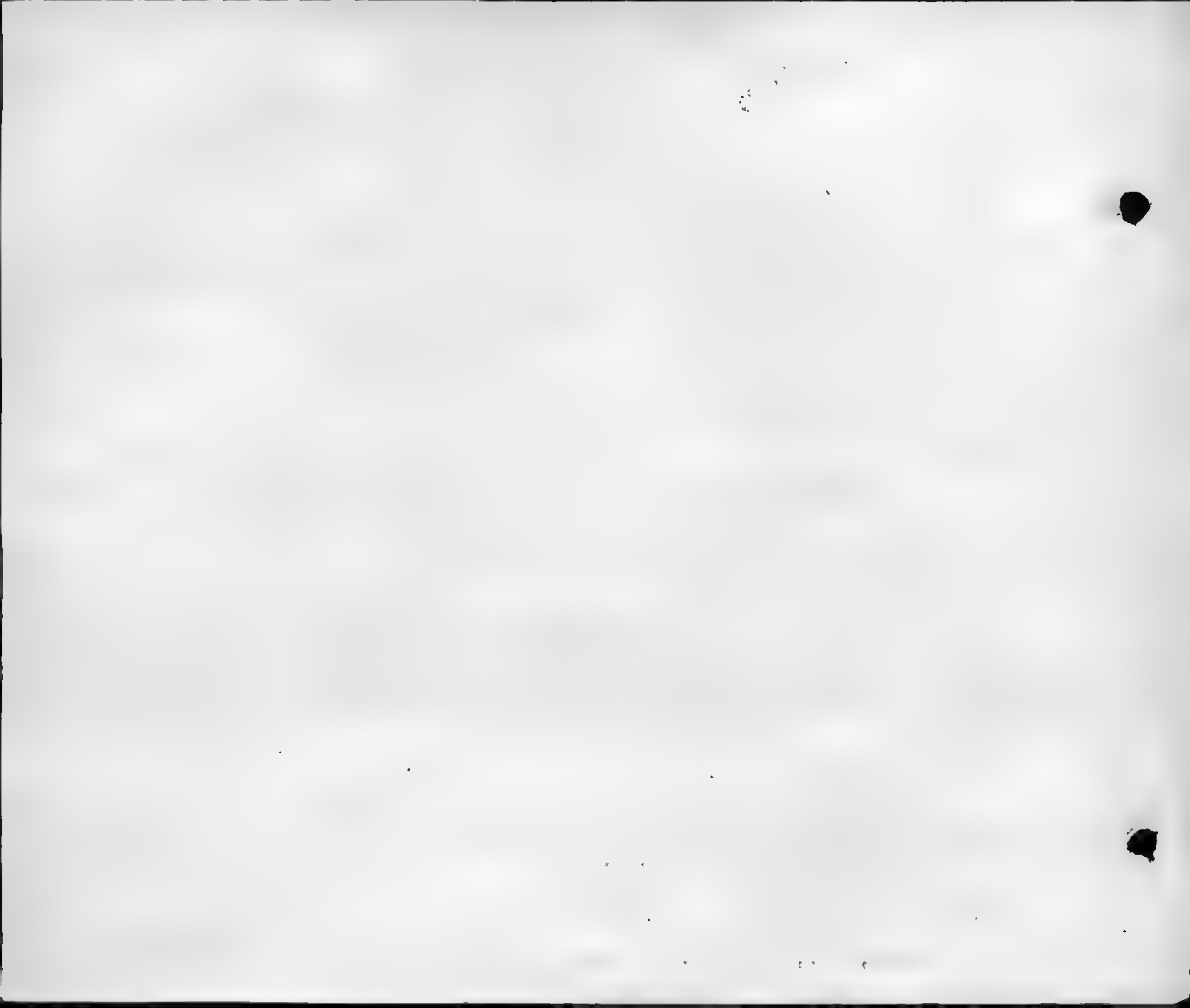
TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the

VR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>2220 Linden Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ruth Puddister</u>		4. DATE OF DEATH Month Day Year <u>February 3 1961</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 28, 1894</u>	
9. AGE (In years last birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis with myocardial infarction</u> (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 10, 1961</u> , to <u>Feb. 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb. 3, 1961</u> , and that death occurred at <u>10:50 a. m.</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Stella Wachslar</u>		22b. DATE SIGNED <u>2-3-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 2nd, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-7-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 8 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1651

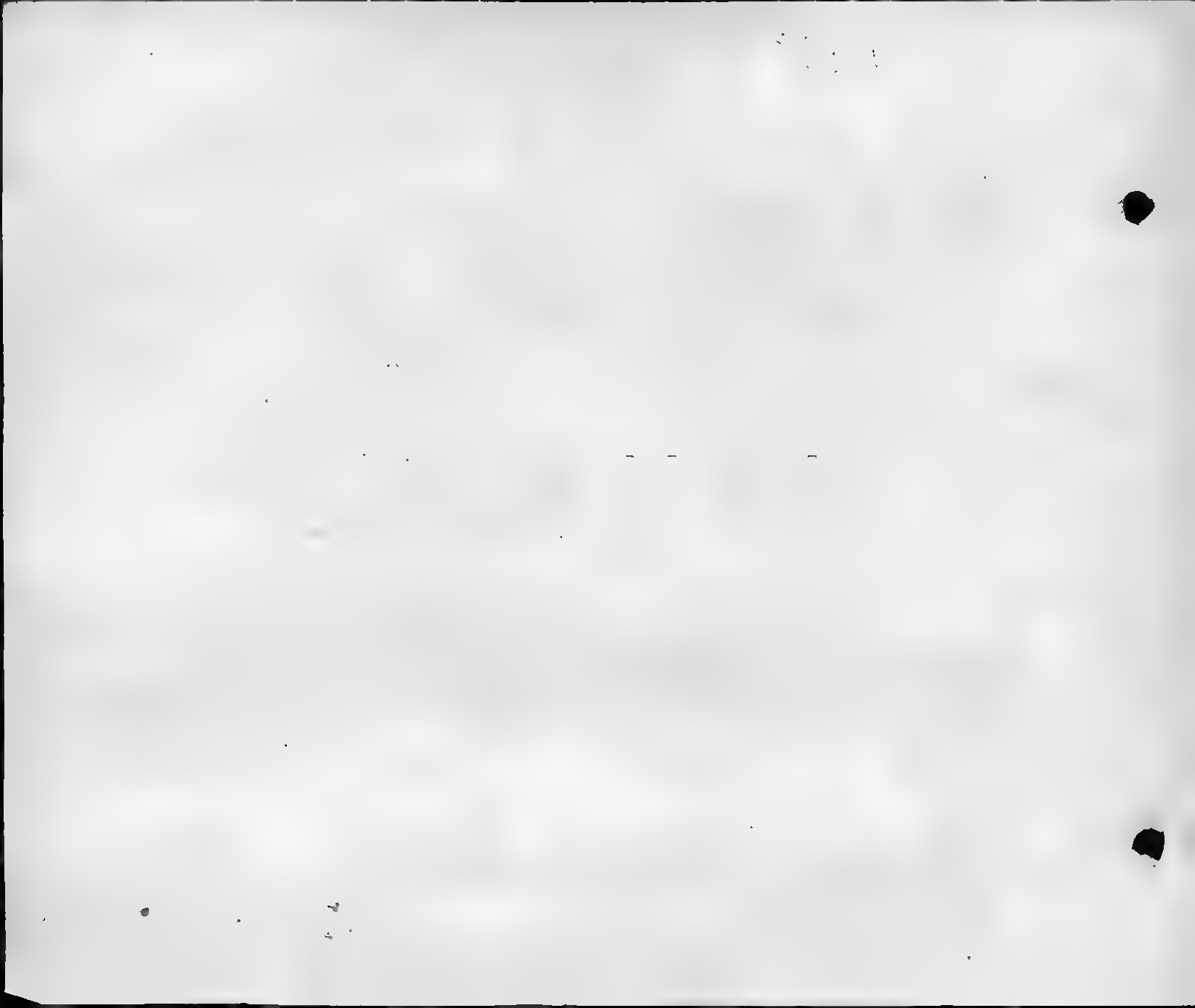
Item 1 Form 231-2-27-61 et **CERTIFICATE OF DEATH**

01631

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> c. LENGTH OF STAY IN TB <u>14 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8405 Charlton Road (Private home)</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2005 Bank Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>PETER EDWARD PULA</u>		4. DATE OF DEATH Month Day Year <u>February 8, 1961</u>		5. SEX <u>Male</u>			
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 28, 1891</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Joseph Pula</u>		14. MOTHER'S MAIDEN NAME <u>Kunegunda Tomalski</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-10-6777</u> 17. INFORMANT <u>Thaddeus J. Pula, 5712 Fenwick Ave</u>					
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous cell Carcinoma Bladder</u> Conditions, if any, which gave rise to immediate cause (b) <u>generalized Metastases</u> (a), stating the underlying cause last. (c) <u>6 mos</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>10/28</u>			
21. I certify that (1) (this hospital) <u>attended the deceased from 10/28</u> to <u>2/8</u> , 19 <u>61</u> , that (1) (we) last saw the deceased alive on <u>2/2</u> , 19 <u>61</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Ther. T. Dizinich M.D.</u>		22b. DATE SIGNED <u>2/8/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Ther. T. Dizinich M.D.</u>			
22d. ADDRESS <u>4795 Chester St. Balto 31 Md.</u>		22e. MED. BY REGISTRAR <input checked="" type="checkbox"/> 22f. MED. DIRECTOR <input type="checkbox"/> 22g. STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>M. F. SADOWSKI & SONS, 1808 EASTERN AVE</u>		23d. LOCATION (City, town, or County) (State) <u>Baltimore, Maryland</u>					
25a. RECEIVED BY REGISTRAR DATE <u>FEB 14 61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kim</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, with in 72 hours after death.

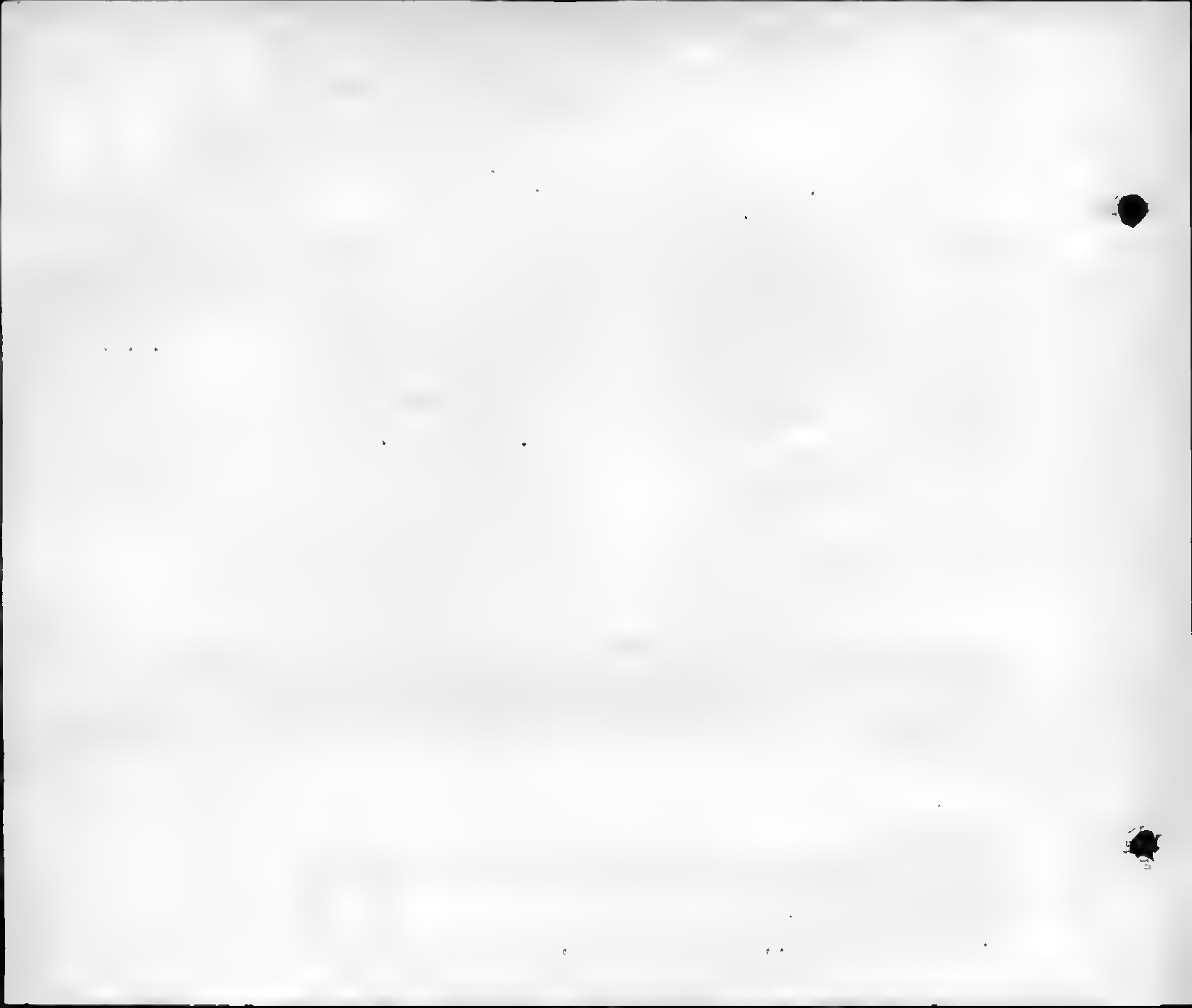
1632

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01632

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Foxleigh Convalescence Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle S. Last Harvey				4. DATE OF DEATH Month February Day 19 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 28, 1899	
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 5 Days 1 Hours 1 Min 1		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Samuel Rabinov				14. MOTHER'S MAIDEN NAME Heligant White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Margaret R. Larichiuta, 1124 Charmuth Road				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cereb. Vas. Accident DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Art. Sclerosis & Myocardial Infarct. DUE TO (c) Secondary aneurysm							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 12 hours							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 1960 to Feb. 12, 1961 , that (I) (we) last saw the deceased alive on Feb. 4, 1961 , and that death occurred at 6:30 M., from the causes and on the date stated above							
22a. SIGNATURE DeBernard J. Cohen				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) DEBERNARD. J. COHEN.				22d. ADDRESS The Marylander apt.			
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 2-15-61		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, Towson, Md.				25a. REC'D BY REG. STRAR DATE FEB 14 1961			
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1655

01635

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay -27	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay		c. LENGTH OF STAY IN IL 1530 S. Rolling Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Residence		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Tena Rice		4. DATE OF DEATH Feb 5 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 17 1868	
9. AGE (In years last birthday) 92		10. IF UNDER 1 YEAR Months 5 Days 5 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Nova Scotia	
11. BIRTHPLACE (County & State, or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Tupper		14. MOTHER'S MAIDEN NAME McDonald	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT R.D. Wheeler		Address 1530 S. Rolling Road -27- Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Dehydration - Gastroenteritis - vomiting DUE TO (c) General arterio sclerosis & cerebral symptoms		INTERVAL BETWEEN ONSET AND DEATH 48 hrs 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) General arterio sclerosis & cerebral symptoms		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 18 1960 to Feb 5 1961 , that (I) (we) last saw the deceased alive on Jan 18 1960 , and that death occurred at 12:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE Frederic V. Butler		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) FREDERICK V. BUTLER		22d. ADDRESS 1014 Francis Ave Balto -27-md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 9, 1961	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE Mac Miller Son Co		25a. REC'D BY REGISTRAR Feb 10 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Thomas		301 Frederick Road 28	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

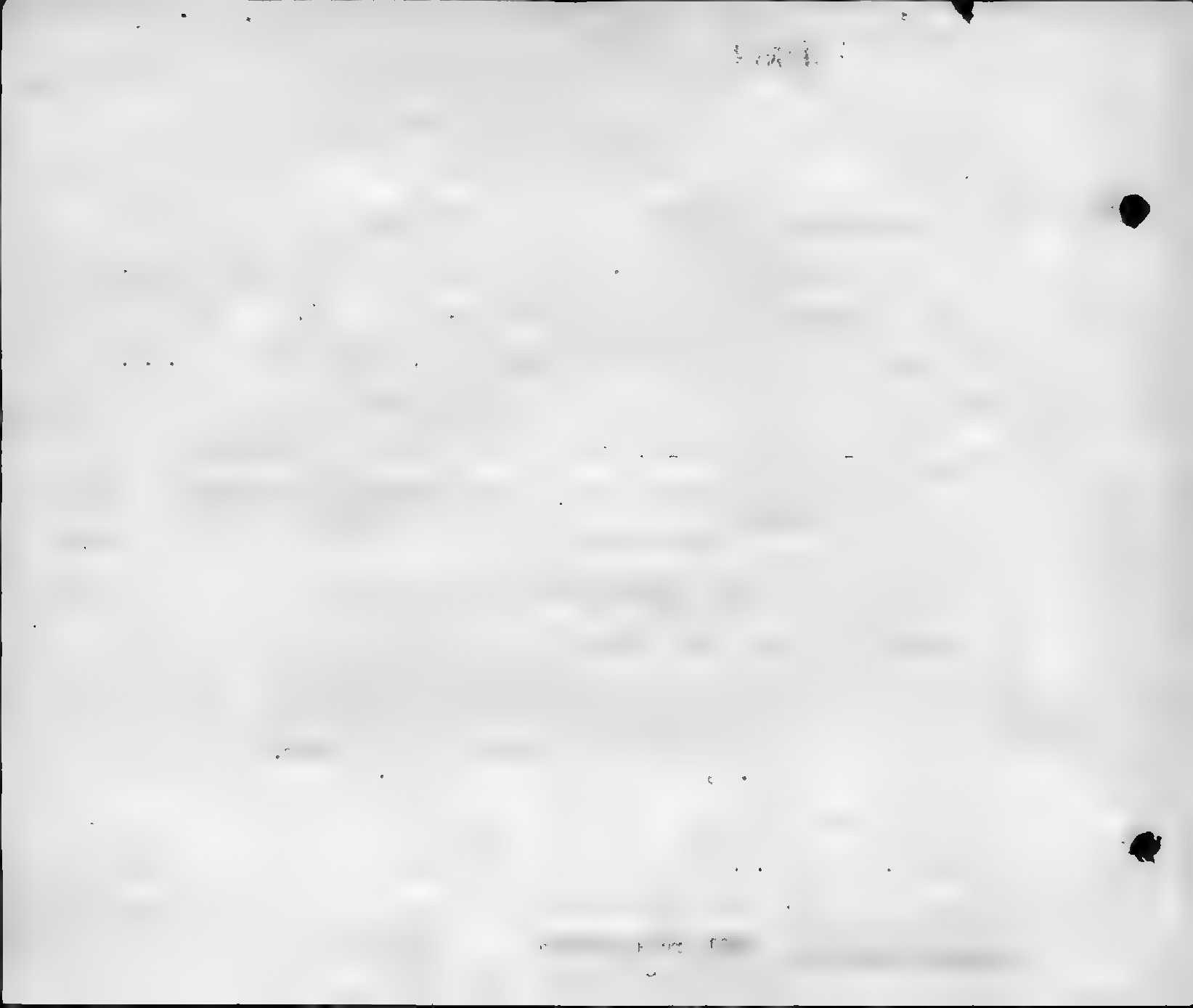
MARYLAND STATE DEPARTMENT OF HEALTH

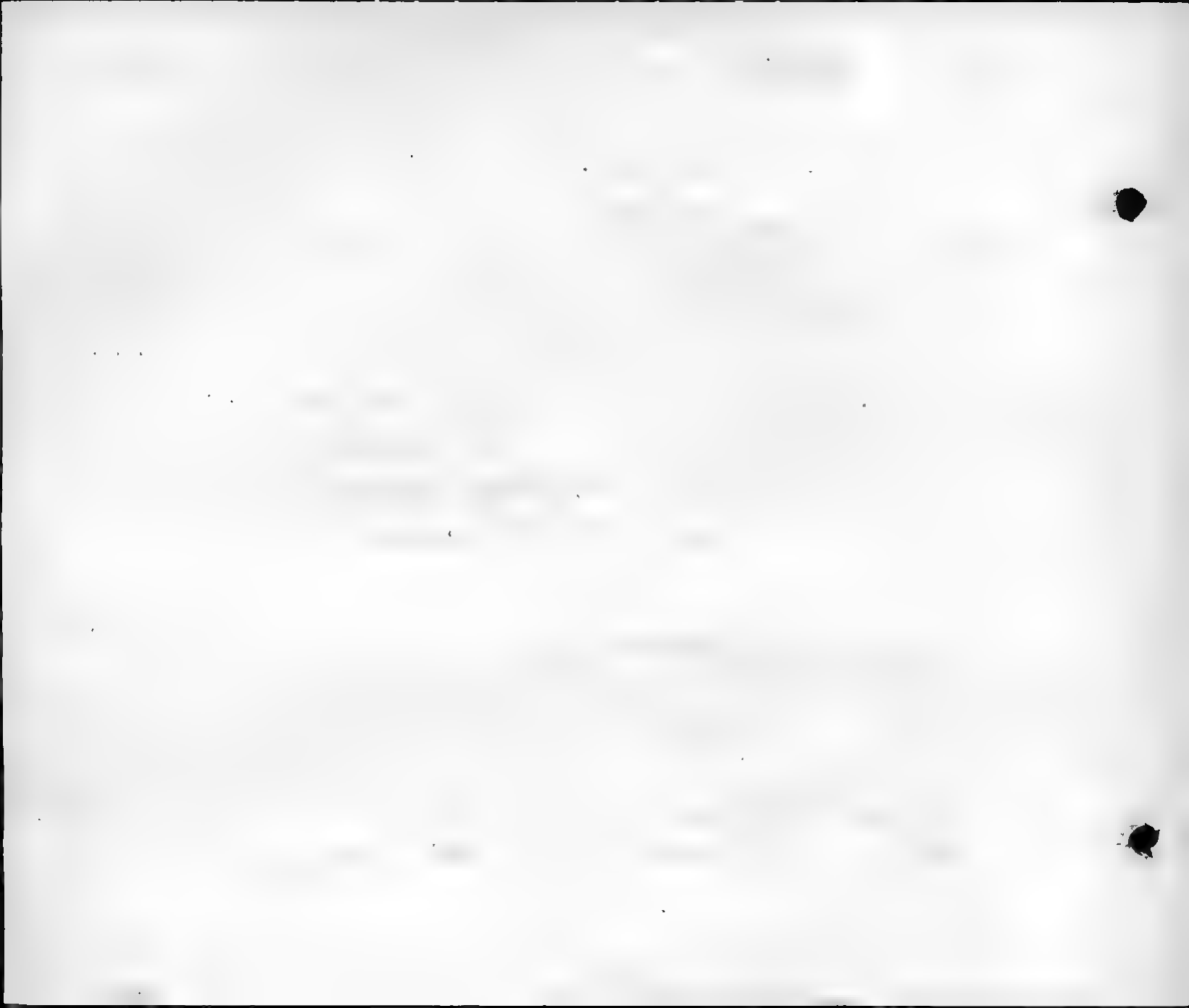
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1653 CERTIFICATE OF DEATH

01653

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 49 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 1811 LINDEN AVENUE					
3. NAME OF DECEASED (Type or print) First Middle Last EARNEST T. RAY		4. DATE OF DEATH Month Day Year FEBRUARY 8 19 61					
5. SEX MALE		6. COLOR OR RACE COLORED					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 13, 1923					
9. AGE (In years last birthday) 37 yrs <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months Days	Hours Min.						
11. BIRTHPLACE (County & State, or foreign country) CLAYTON, NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JAMES WILLIAM RAY		14. MOTHER'S MAIDEN NAME IDA THOMASON					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW-II		16. SOCIAL SECURITY NO 238-24-7032					
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LOBAR PNEUMONIA, LEFT LOWER/RIGHT UPPER LOBES Conditions, if any, which gave rise to immediate cause (b) NEPHROSCLEROSIS (c) HYPERTENSION DUE TO (b) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UREMIA - Duration 1 Week - dueto (b)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					
20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH BALTO MD FT HOWARD DIVISION					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 21, 1960 to Feb. 8, 1961 that XX (we) last saw the deceased alive on Feb. 8, 1961 and that death occurred at 6:00 P.M. from the causes and on the date stated above		22a. SIGNATURE Thomas F. Crahan M.D. 22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.					
22b. DATE SIGNED 2-9-61		22d. ADDRESS VAH BALTIMORE 18 MD-FT HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12 Feb 61					
23c. NAME OF CEMETERY OR CREMATORY PINEY GROVE CHURCH CEMETERY		23d. LOCATION (City, town or county) (State) CLAYTON NORTH CAROLINA					
24. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home		25a. REC'D BY REGISTRAR FEB 14 '61					
25b. REGISTRAR'S SIGNATURE Carlton S. Kraus		25c. ADDRESS Baltimore 17 Md					





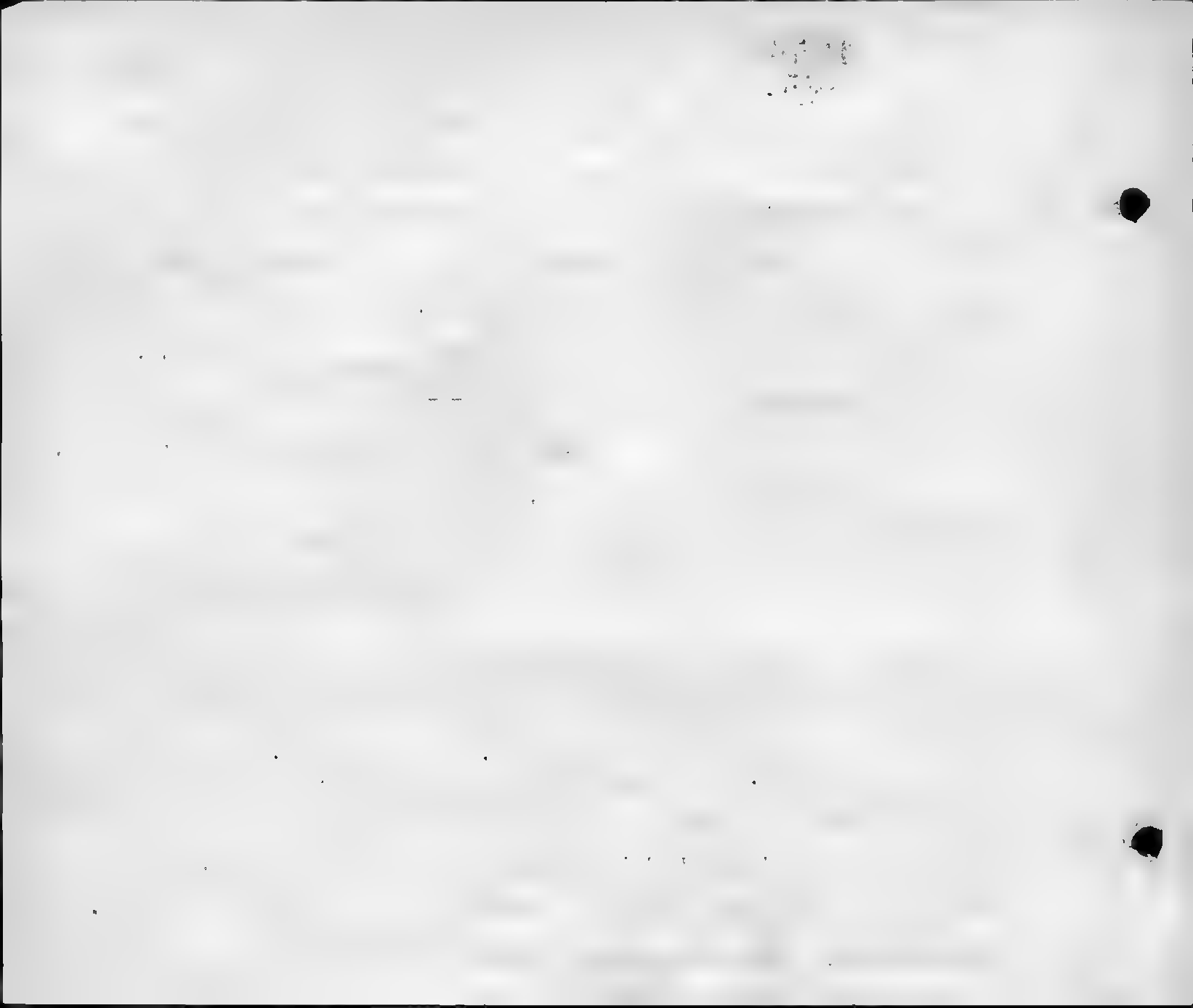
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				a. STATE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN TB				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
Baltimore				Maryland			
Catonsville				Catonsville			
105 Locust Drive				105 Locust Drive			
13. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
Rena Richwein				February 15 1961			
5. SEX				6. COLOR OR RACE			
Female				White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH			
				August 10, 1875			
9. AGE (In years last birthday)				9. AGE (In years last birthday)			
85 yrs.				85 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
Housewife				Germany			
11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
U.S.				U.S.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Ernest Bettenhausen				Schaeffer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO			
				Mrs Katherine Gibson 105 Locust Drive-28- Md.			
17. IN OR MANT				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:				2. Date			
IMMEDIATE CAUSE (a)				Unknown			
4-20-1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				Arteriosclerotic Cardio-Vascular Disease			
(b)							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY				20d. INJURY OCCURRED			
Month, Day, Year				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
Hour a.m. p.m.				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
19				20f. (City or town) (County) (State)			
21. I certify that (I) (husband) attended the deceased from Feb. 13, 1961 to Feb. 15, 1961, that (I) (was) last saw the deceased alive on Feb. 13, 1961, and that death occurred at 1:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE			
Leo J. Gaver, M.D.				2/15/61			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
				1 Willow Hill Ave., Baltimore 29, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF			
Burial				2-18-1961			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
Loudon Park Cemetery				Baltimore Md.			
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
Mac Nath-Lewis, Home				25b. REGISTRAR'S SIGNATURE			
301 Frederick Rd 28-				DATE FEB 20 61			



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1657

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01657

1. PLACE OF DEATH a. COUNTY Baltimore County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 41 mo 21 da.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md.		b. COUNTY Cecil		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		d. STREET ADDRESS Maywood Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Irene		Middle L.		Last Rogers		4. DATE OF DEATH Month 2		Day 28		Year 1961		5. SEX F.		6. COLOR OR RACE W					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/5/16		9. AGE (In years last birthday) 44 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Factory Worker		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME J. Clyde Light		14. MOTHER'S MAIDEN NAME Ossie Hadford					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 228-03-7315		17. INFORMANT Hospital Records, Mt. Wilson State Hospital		18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) For Advanced Pulmonary Tuberculosis (c) 10 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/19/57 to 2/28/61 that (I) (we) last saw the deceased alive on 2/28/61 and that death occurred at 8:30 p.m. from the causes and on the date stated above.																			
22a. SIGNATURE W. Newcomer				22b. DATE SIGNED 2/28/61				22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF 3-1-61				23c. NAME OF CEMETERY OR CREMATORY ?				23d. LOCATION (City, town, or county) (State) Floyd Co. Roanoke, Virginia							
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickert, Sr. M & P Co Baltimore				25a. REC'D BY REGISTRAR DATE MAR 3 '61				25b. REGISTRAR'S SIGNATURE Arthur L. Hanna											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
1494 Items 11 & 12 Film 288 3/2/61									
CERTIFICATE OF DEATH 01638									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived, if distinct from residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3013 Linwood Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		d. STREET ADDRESS <u>3013 Linwood Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Anna Eleanor Romig</u>		4. DATE OF DEATH <u>February 5th 19 61</u>		5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Mar. 11, 1880</u>		9. AGE (In years last birthday) <u>80</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Conrad Pfarr</u>		14. MOTHER'S MAIDEN NAME <u>Margaretha Peppersack</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give year or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Mrs. Anna E. Richards</u>		17. INFORMANT <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>3yr</u> DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. [City or town, (County, (State)]		21. I certify that (I) (the hospital) attended the deceased from <u>2 Jan</u> ..., 19 <u>61</u> , to <u>5 Feb</u> ..., 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>5 Feb</u> ..., 19 <u>61</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.		22a. SIGNATURE <u>Howard Goodman</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard Goodman</u>		22d. ADDRESS <u>8604 Harford Road</u>		22b. DATE SIGNED <u>6 Feb 61</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-8-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u>		23e. REC'D BY REGISTRAR <u>Leonard J. Ruck</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24b. ADDRESS <u>5305 Harford Road #14</u>		25. REC'D BY REGISTRAR <u>FEB 8 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. DATE	

42-1

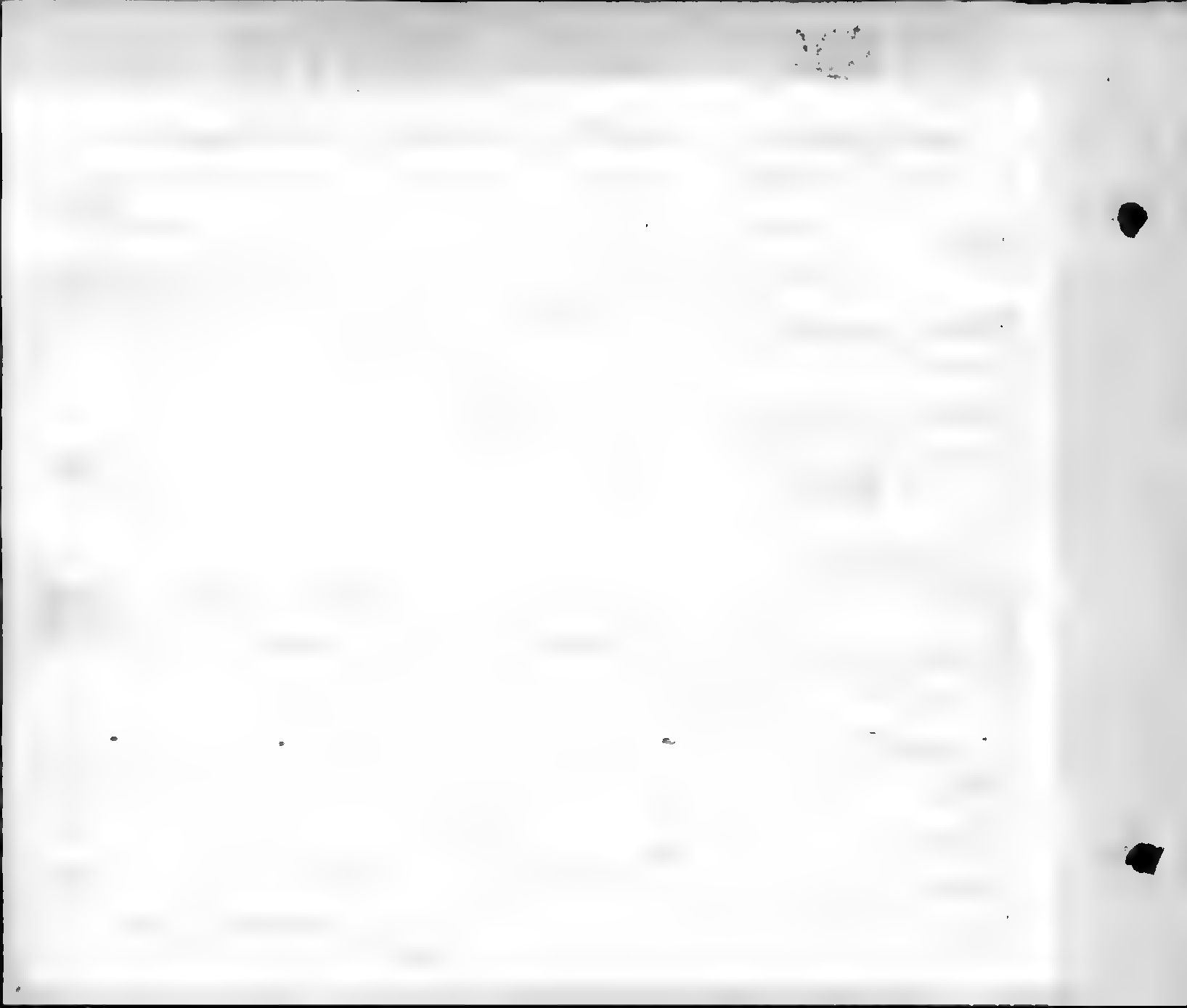
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4-1

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1658
CERTIFICATE OF DEATH

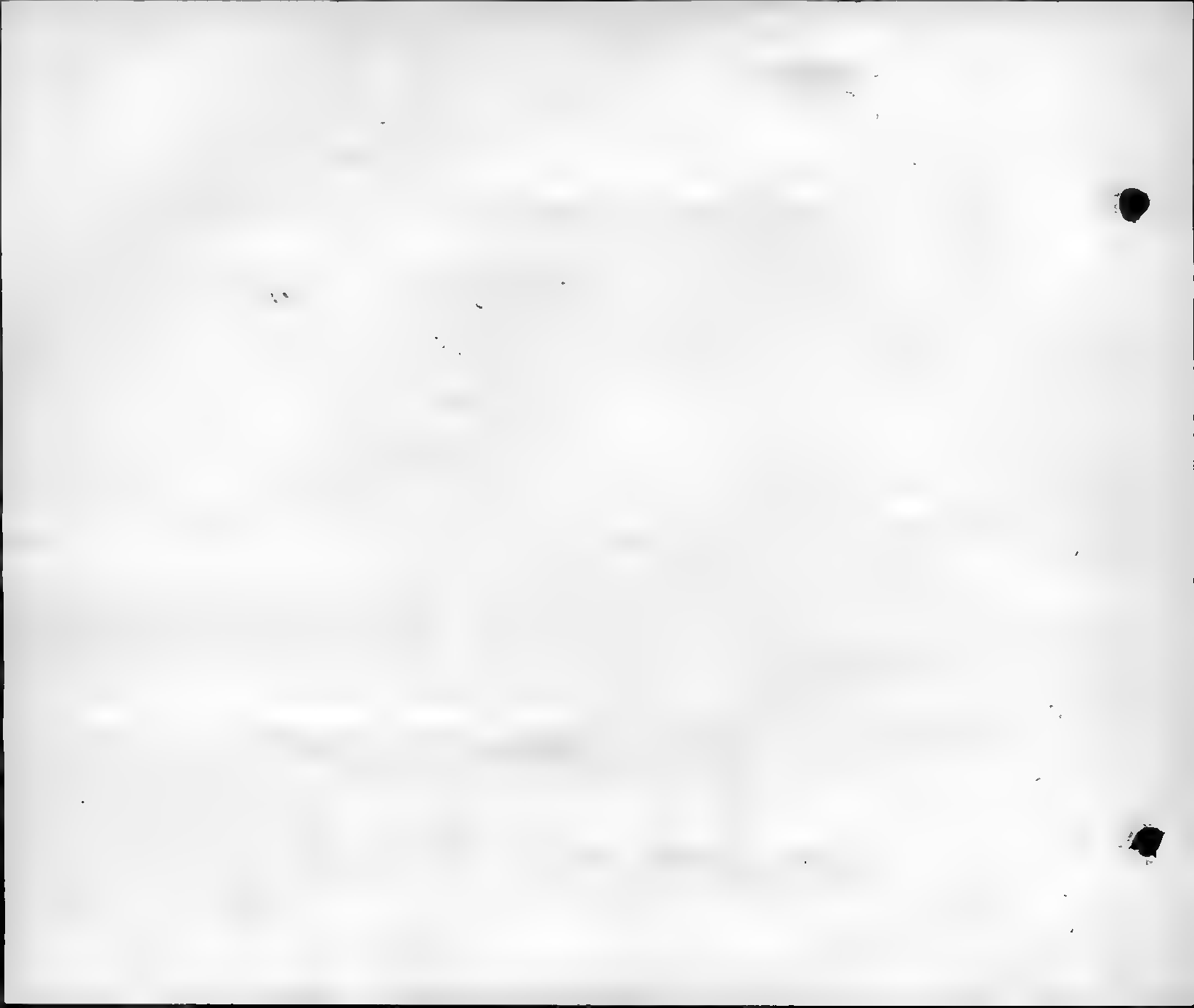
01633

1. NAME OF DECEASED (Type or Print) FRANCIS EDWARD ROSE		2. DATE OF DEATH Feb. 21, 1961	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Baltimore County</i> Ridgeway Manor Nursing Home 4743 Edmondson Ave. Baltimore Md.		4. USUAL RESIDENCE (Where deceased lived If institution residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1414 Light St.	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 7, 1881
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (In years last birthday) 79
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Francis Edward Rose, Sr.		14. MOTHER'S MAIDEN NAME Kate R. V. Blundell	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-01-0260	
17. INFORMANT Mrs. Rose Lee Price, Springfield, Del. Co. Pa.		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death) 177 X (A) Carcinoma of Prostate Gland ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Arteriosclerotic Heart Disease (C) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 230			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
IF OPERATION WAS RELATED TO CAUSES OF DEATH ENTER IN PART I OR PART II		19A. DATE OF OPERATION Jan 16	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Prostatectomy
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from Jan 16 to Feb 21 19 61 and that in (my) (our) opinion death occurred at 4:30 P. M. from the causes and on the date stated above.			
23A. SIGNATURE Francis M. M... M.D.		23B. ADDRESS 1414 Light St.	23C. DATE SIGNED 2/21/61
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 2-24-61	24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. FEB 24 '61		25B. NAME OF REGISTRAR Arthur S. Hanna	25C. FUNERAL DIRECTOR FLYNN & FLEMING, INC. 1422 Light St.



FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

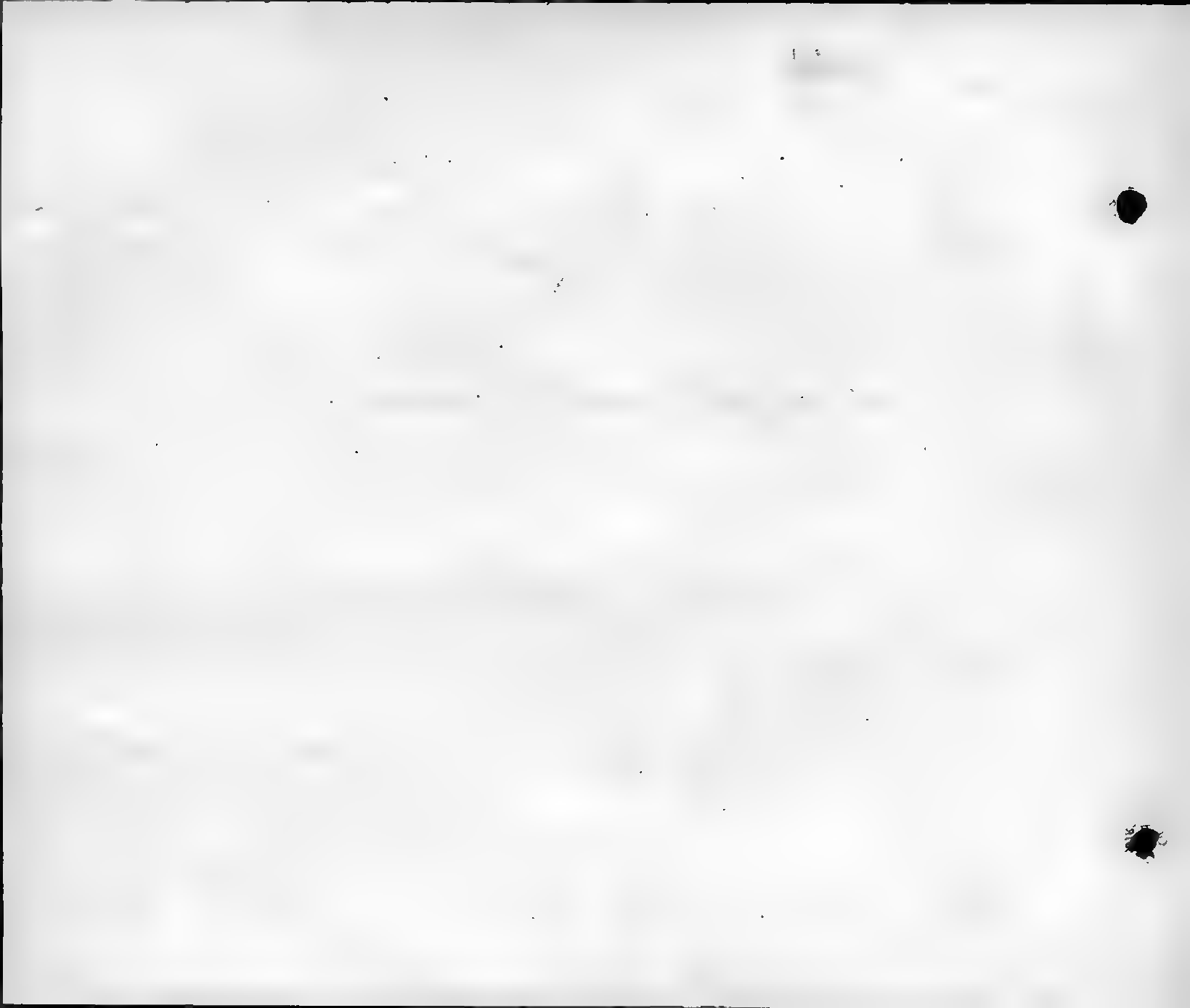


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01641

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>---</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7708 Crossland Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Naron</u> Middle <u>Samuelson</u> Last <u>---</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>21</u> - Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-13-1898</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>	11. IF UNDER 24 HRS Min. <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Samuel David Samuelson</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Ella</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>war I</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Israel M Miller - same</u>		Address <u>---</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u>		INTERVA. BETWEEN ONSET AND DEATH <u>Sudden</u>	
b. <u>Acute coronary occlusion</u>		Sec. 1957	
c. <u>Indurated atherosclerosis</u>		Jan 12/61	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>---</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 13, 1961</u> to <u>Feb 17, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 13, 1961</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Jack Lewis</u> M.D.		22b. DATE SIGNED <u>2/21/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>---</u>		22d. ADDRESS <u>2933 N. Charles St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-23-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Beth Tfiloh</u>	23d. LOCATION (City, town or county) (State) <u>Balto Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>3100 Eutan Place</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 23 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Clifford L. Hines</u>	

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
 TO HOSPITAL: may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and 3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

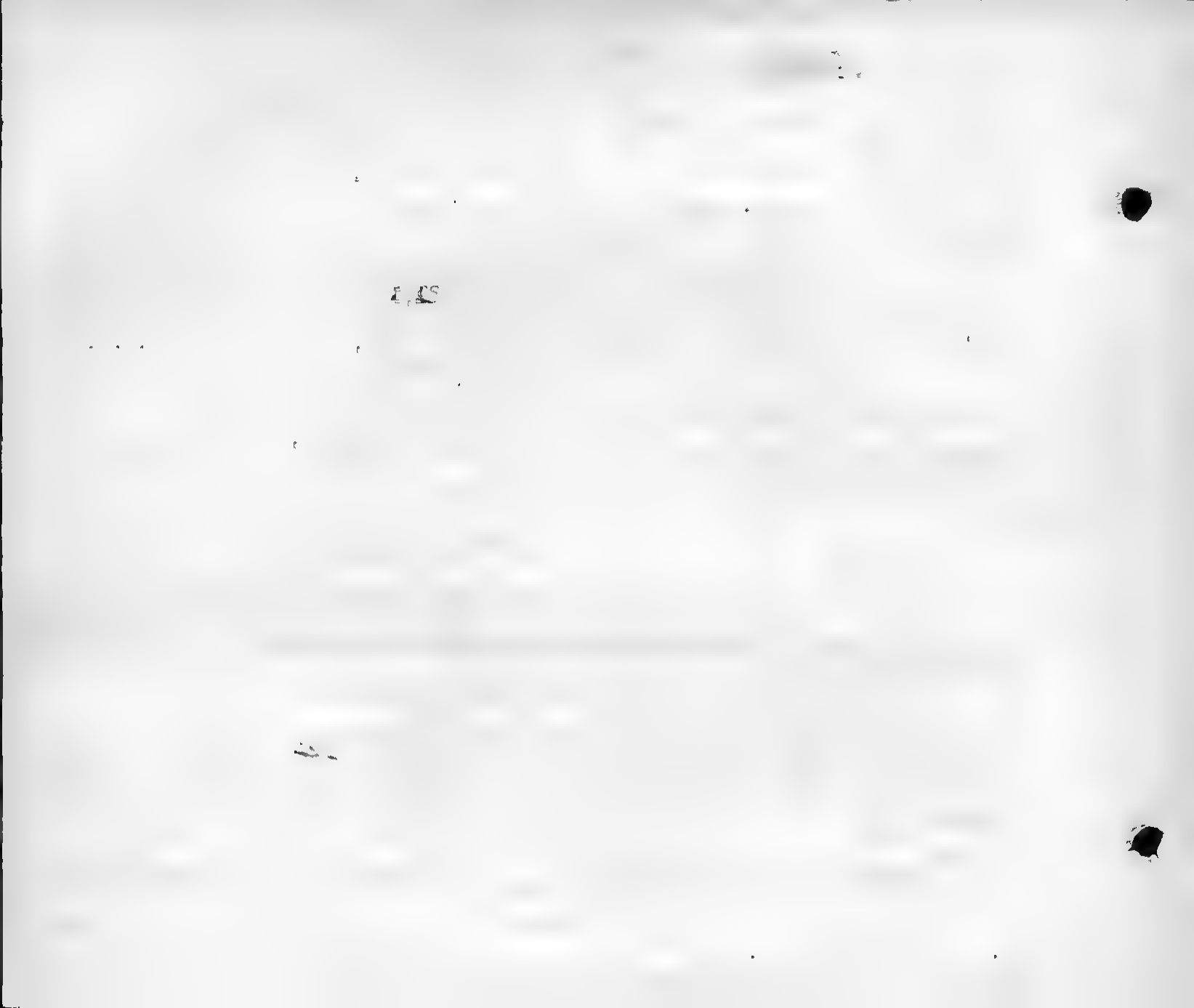
Reg. Dist. No.

01642

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Conval. Home		d. STREET ADDRESS Marylander Apts	
3. NAME OF DECEASED (Type or print) First ANNE Middle MAUDE Last SANSBURY		4. DATE OF DEATH Month February Day 24 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 February 21, 1876
9. AGE (In years last birthday) 85 yrs		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Ret'd) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Sansbury		14. MOTHER'S MAIDEN NAME Carrie Flack	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Miss Carolyn Hogendorp		Address 4 East 32nd Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 16, 1960 to Feb 24, 1961 , that I last saw the deceased alive on Feb 24, 1961 , and that death occurred at 8 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Laurence C. Post		M.D. 6805 York Rd. DATE SIGNED 2-25-61	
PHYSICIAN'S NAME (Type) LAURENCE C. Post		Baltimore 12 Md	
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) BURIAL	22b. DATE THEREOF 2-27-61	22c. NAME OF CEMETERY OR CREMATORY Green Mount	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE FEB 28 '61	24b. REGISTRAR'S SIGNATURE William S. Kneib

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1662 : Item 11 Film 6-21-61 et 01643											
1. PLACE OF DEATH											
a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)		a. STATE		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Lutherville		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		College Manor		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		3700 N. Charles Street		9. AGE (in years last birthday)		IF UNDER 1 YEAR	
3. NAME OF DECEASED (Type or print)		Norma		Middle		A. Sauter		4. DATE OF DEATH		Month Day Year	
5. SEX		Female		6. COLOR OR RACE		White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH		July 16, 1879	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		None		10b. KIND OF BUSINESS OR INDUSTRY		None		11. BIRTHPLACE (County & State, or foreign country)		Baltimore, Maryland	
13. FATHER'S NAME		William Sauter		14. MOTHER'S MAIDEN NAME		Agatha Tschudy		12. CITIZEN OF WHAT COUNTRY?		U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		No		16. SOCIAL SECURITY NO.		None		17. INFORMANT		Mr. William S. LaPorte	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral thrombosis		DUE TO		INTERVAL BETWEEN ONSET AND DEATH		Days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Cerebral arteriosclerosis		DUE TO		(c)		yrs -	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Form 18)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 6-21-61 to 2-23-61, 1961, that (I) (we) last saw the deceased alive on 2-16-61, 1961, and that death occurred at 11:03 P.M. from the causes and on the date stated above.											
22a. SIGNATURE		Ernest C. Brown Jr.		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED		2-21-61	
22c. PHYSICIAN'S NAME (Type)		Ernest C. Brown, Jr., M.D.		22d. ADDRESS		1101 N. Calvert Street, Baltimore 2					
23a. BURIAL, CREMATION, REMOVAL, Specify)		Burial		23b. DATE THEREOF		2/23/61		23c. NAME OF CEMETERY OR CREMATORY		Druid Ridge	
23d. LOCATION (City, town or county)		Pikesville, Md.		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE					
24. FUNERAL DIRECTOR'S SIGNATURE		Wm. J. Tuckner		ADDRESS		North & Pa. Balto. Md.		DATE		FEB 24 '61	

1954



CERTIFICATE OF DEATH

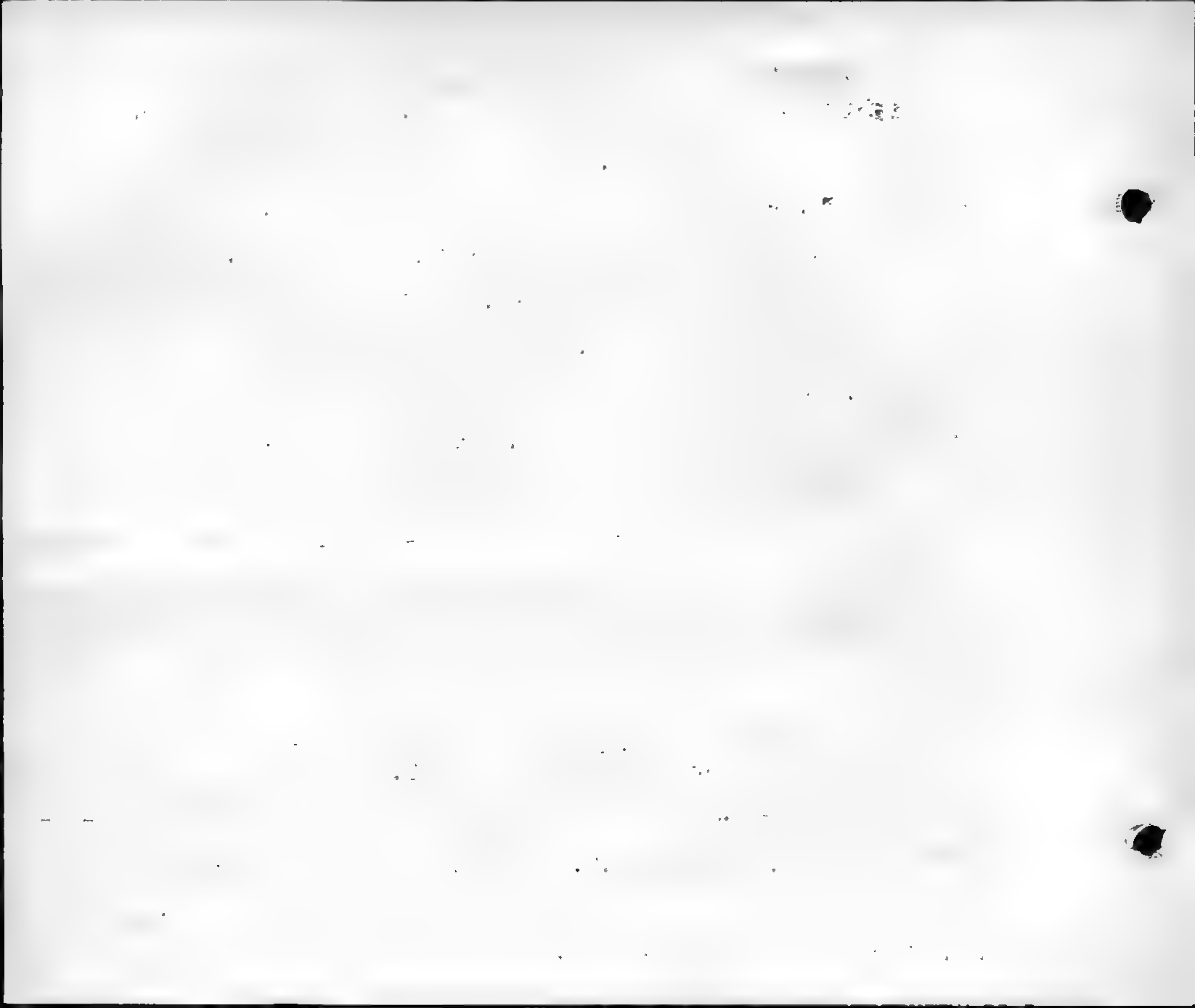
Reg. Dist. No.

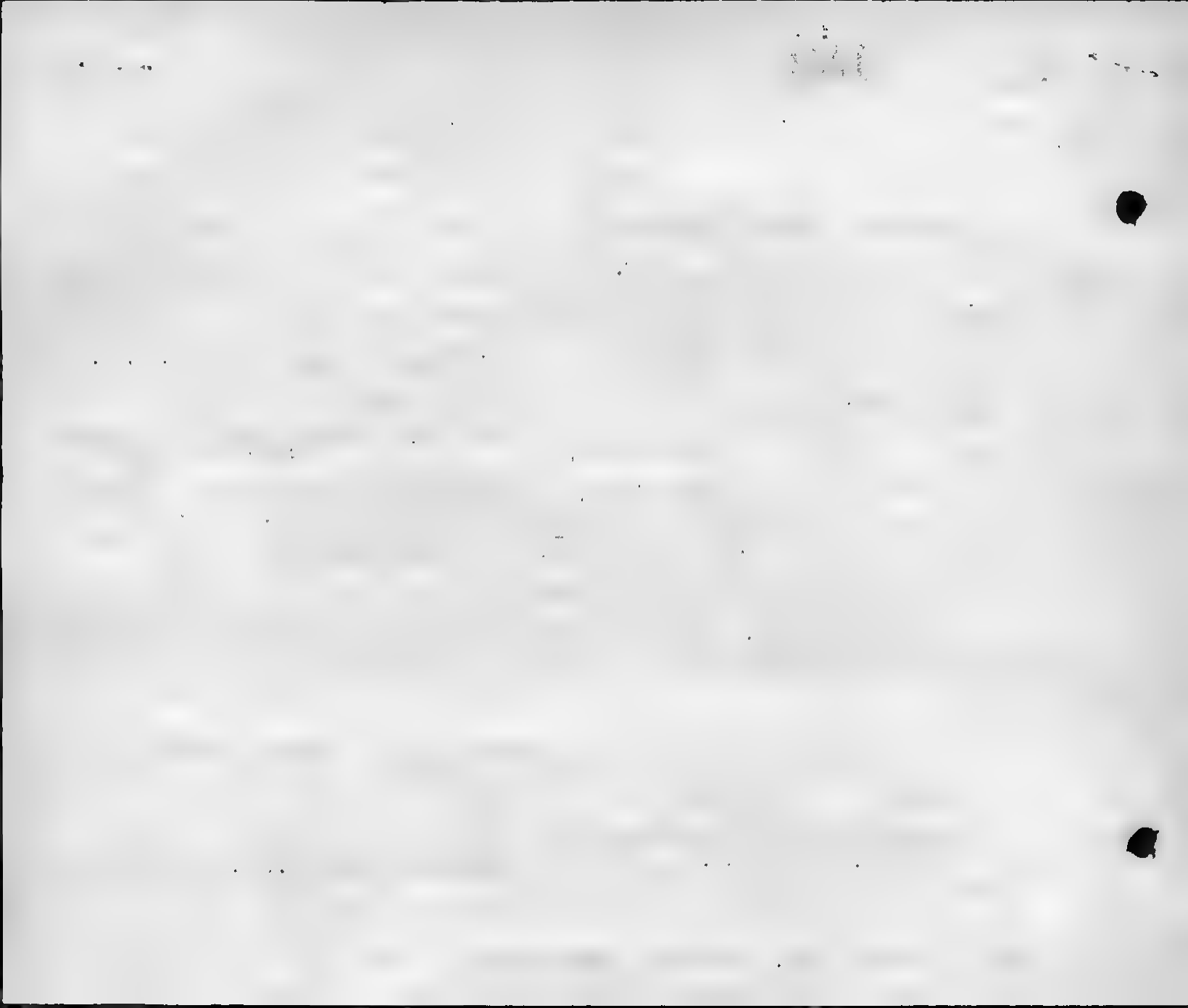
01644

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN lb 11 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20 Woodley Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Francis Middle Brown Last Schaeffer		4. DATE OF DEATH Month Feb. Day 25 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1912
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months 48 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction for Gas & Electric Co.		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles A. Schaffer		14. MOTHER'S MAIDEN NAME Elsie Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-03-5708	
INFORMANT Mrs. Erma Schaeffer		Address Reisterstown	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio-Vascular Disease DUE TO (c) 1 hour 1 year			INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 1, 1950 to February 25, 1961 , that I last saw the deceased alive on February 25, 1961 , and that death occurred at 9 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin E. Strobel		ADDRESS (Street, city or town, state) 48 Main Street	
PHYSICIAN'S NAME (Type) Martin E. Strobel, M.D.		DATE SIGNED 2-27-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 1, 1961	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR DATE FEB 28 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

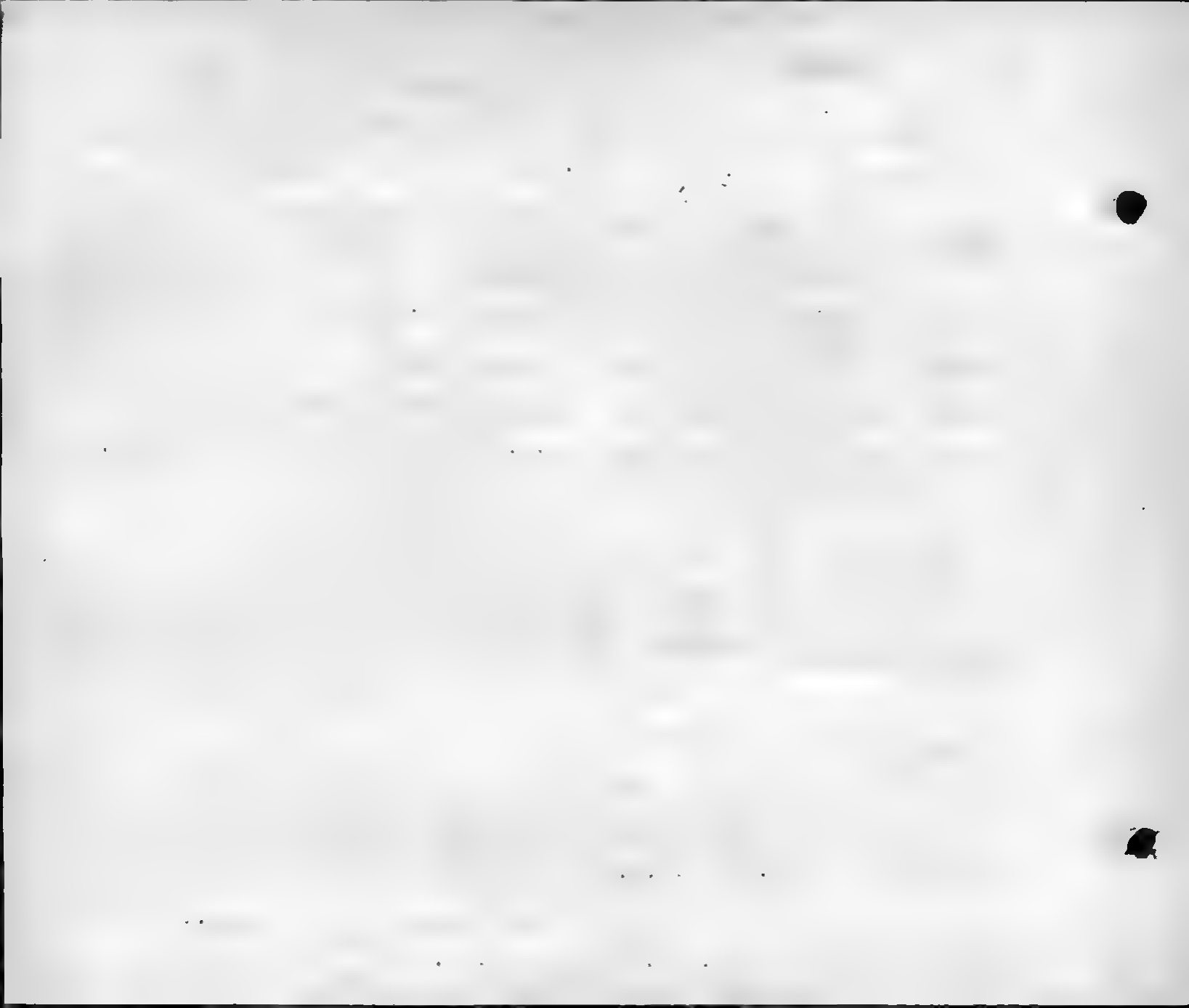
01646

1663

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN 1b 37 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dundalk (22)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6737 Pine Avenue				d. STREET ADDRESS 1 6737 Pine Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle MATTHEW Last SCHRIEFER				4. DATE OF DEATH Month February Day 8th Year 19 61			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28th, 1896		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Metal		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Schriefer				14. MOTHER'S MAIDEN NAME Louise Kaiser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 		17. INFORMANT J.E. Schriefer Address 1769 Brookview Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 17-S-C-V DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M B Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/9/61			
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/11/61		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md				24a. REC'D BY REGISTRAR FEB 14 1961		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1666 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01647

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockdale, Baltimore 3 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockdale, Baltimore 7</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>(Lynn Ave.) 3327 Northmont Rd.</u>		d. STREET ADDRESS <u>3327 Northmont Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>PHILIP</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 21, 1923</u>	
9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u>	
11. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Max Schved</u>		14. MOTHER'S M.A.DEN NAME <u>Estella Schved</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>311-26-7621</u>	
17. INFORMANT <u>Max Schved</u>		Address <u>3327 Northmont</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shot thru head (suicide)</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>None</u> (a), stating the underlying cause last. DUE TO (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part I. of Item 18) <u>Self-inflicted</u>	
20c. TIME OF INJURY Month <u>Feb</u> Day <u>2</u> Year <u>1961</u> Hour <u>5:00</u> a.m. <u>no</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Baltimore</u> (County) <u>Baltimore</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>D.D. Caples</u> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D.D. CAPLES</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>Baltimore, Maryland</u>		DATE SIGNED <u>Feb 2 '61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2-4-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR <u>Wm J. Schved</u>		24a. REC'D BY REGISTRAR <u>Baltimore 17, Md</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>FEB 3 '61</u>	

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CERTIFICATE OF DEATH

Reg. Dist. No. 01648

1667

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. LENGTH OF STAY IN 1b <u>9 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1826 Shepherd Ave</u>		e. STREET ADDRESS <u>17826 Shepherd Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Hehen M Schweiger</u>		4. DATE OF DEATH <u>Feb. 25, 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 13 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>RAVERS</u>		14. MOTHER'S MAIDEN NAME <u>LOU TANNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Daughter</u>		Address <u>Same.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paget's Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 1956</u> , to <u>February 1961</u> , that I last saw the deceased alive on <u>February 24 1961</u> , and that death occurred at <u>9⁰⁰</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. F. Palmisano</u> M. D.		ADDRESS (Street, city or town, state) <u>6608 Loch Raven Blvd.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>J. F. Palmisano, M. D.</u>		Baltimore 12, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/28/1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CARL LANN</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas F Evans & Son</u>		ADDRESS <u>8802 Hartford Rd</u>	24a. REC'D BY REGISTRAR <u>MAR 6 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

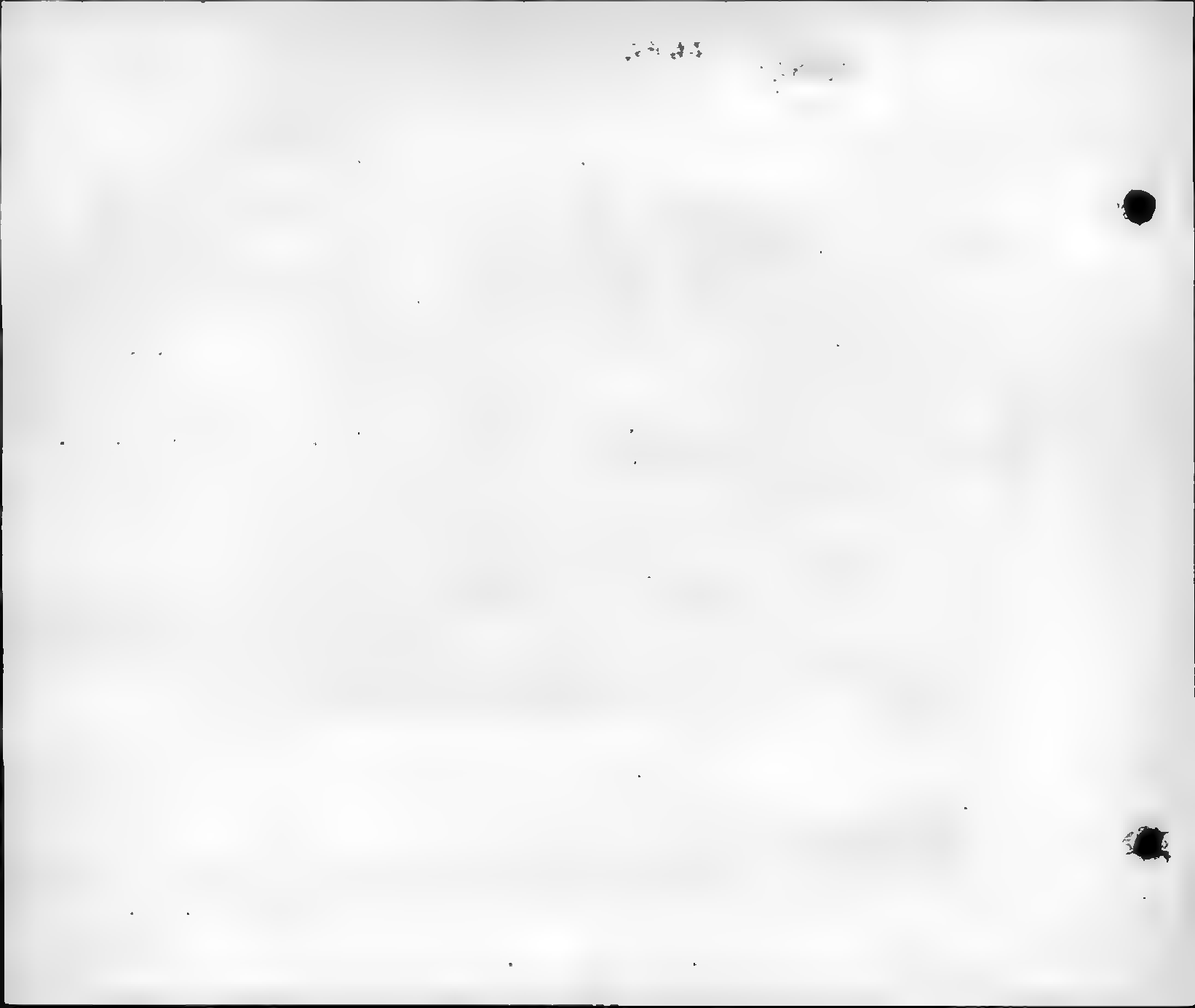


STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1668

02822

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4,			c. LENGTH OF STAY IN 1b 17 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4, M	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 1/2 Linden Terrace				d. STREET ADDRESS 14 1/2 Linden Terrace			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Ethel Francis Sewell				4. DATE OF DEATH Month Day Year 2-26-61 19			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1880		9. AGE (In years last birthday) 81 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) , housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Charles Francis				14. MOTHER'S MAIDEN NAME Ida Morgan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO (If yes, give war or dates of service) none		17. INFORMANT Address Mr Stanley Schmidt, Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Generalized Arterio-sclerotic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Renal Vascular Disease DUE TO 10 yrs (c) 10 yrs							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from act 19 57 to 2/26, 1961 , that (I) (<input checked="" type="checkbox"/>) last saw the deceased alive on 2/26, 1961 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Charles F. O'Donnell M.D.				22b. ADDRESS Charles F. O'Donnell M.D. 501 York Rd Towson 4 Md		22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-1-61		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City, town, or county) (State) Pikesville 8, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.				25a. REC'D BY REGISTRAR DATE MAR 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

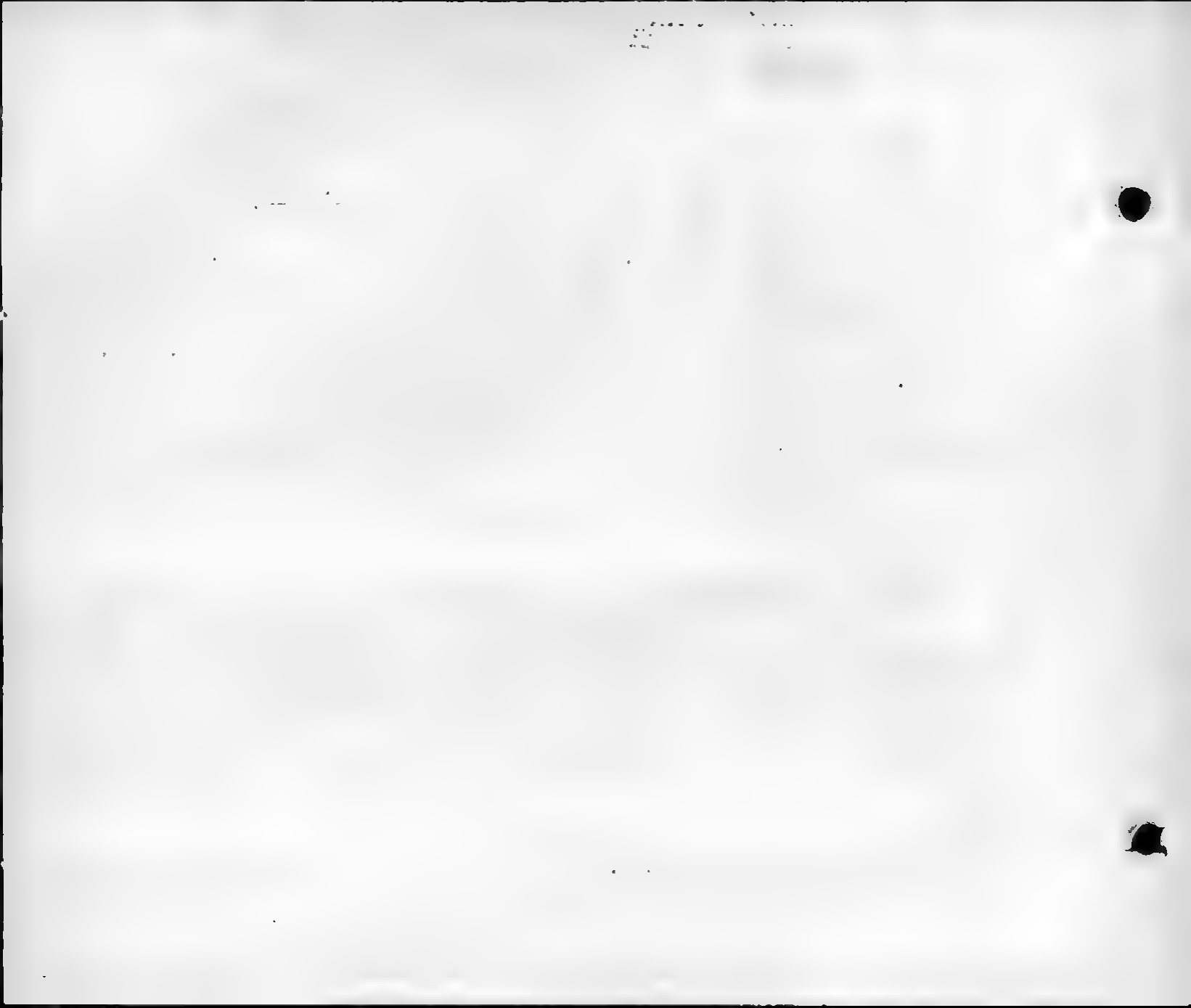
Reg. Dist. No.

01649

1669

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 24yr4mth29dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 1307 W. North Avenue 1515 Washington Blvd.		g. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle W. Last Shaw		4. DATE OF DEATH Month Feb. Day 16 Year 19 61	
5 SEX male	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1874
9 AGE (In years last birthday) 86 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY transit company	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Shaw		14. MOTHER'S MAIDEN NAME Margaret Mary Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes Span-Amer.		16. SOCIAL SECURITY NO 213-05-9089-A	
17 INFORMANT Records; SPRING GROVE STATE HOSPITAL		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition and the insufficiency		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan; 17 , 19 59 , to 1 , 19 61 , that I last saw the deceased alive on 12 , and that death occurred at 6 15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar, M. D.		DATE SIGNED SPRING GROVE STATE HOSPITAL 2-16-61	
NAME (Type) Catonsville 28, Maryland			
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b DATE THEREOF 2-18-61	
22c NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23 FUNERAL DIRECTOR'S SIGNATURE Wm J. Tucker & Sons Balto 17, Md		24a. REC'D BY REGISTRAR DATE FEB 17 '61	
ADDRESS Balto 17, Md		24b. REGISTRAR'S SIGNATURE Arthur S. House	

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1670
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01650

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2yr2mth27days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 607 Grantley Street			
3 NAME OF DECEASED (Type or print) First Middle Last Elsie Sheridan				4. DATE OF DEATH Month Day Year February 23 19 61			
5 SEX female	6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1883	9 AGE (In years last birthday) yrs 78	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	
10a. USJA. OCCUPATION (Give kind of work done: during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Unknown				14 MOTHER'S MAIDEN NAME Unknown			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. 215-03-9793			
17 INFORMANT Address Records: SPRING GROVE STATE HOSPITAL							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 Acute cardiac failure DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO							
(c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 26 19 58 to Feb. 23 19 61 that (I) (we) last saw the deceased alive on Feb. 23 19 61, and that death occurred at 7:00 a. m. from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar				22b. DATE SIGNED 2-23-61			
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				22d. ADDRESS 22b ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION OR REMOVAL (Specify)		23b. DATE THEREOF 2/27/61		23c. NAME OF CEMETERY OR CREMATORY Landon Park		23d. LOCATION (City, town, or county) (State) Frederick, Md	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Foley + Sons				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ADDRESS 1518 Light St				DATE FEB 27 '61		Clifford S. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1671

CERTIFICATE OF DEATH

01651

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN (b) <u>80 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> d. STREET ADDRESS <u>9007 Orchard View Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN H. SHIFLETT</u>		4. DATE OF DEATH <u>February 11, 1961</u>		9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>McGaheysville, Virginia</u>		11. BIRTHPLACE (County & State, or foreign country, U.S.A.)	
13. FATHER'S NAME <u>John W. Shiflett</u>		14. MOTHER'S MAIDEN NAME <u>Alice S. Williams</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give word or dates of service) <u>WW-1</u>	
16. SOCIAL SECURITY NO. <u>212-14-3048</u>		17. INFORMANT <u>Clinical Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA OF SIGMOID COLON WITH METASTASIS</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>TO LIVER</u> DUE TO <u>3 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY EDEMA, BRONCHOPNEUMONIA</u>					
20a. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20d. (City or town, (County) (State)		20e. (City or town, (County) (State)		20f. (City or town, (County) (State)	
21. I certify that (b) (this hospital) attended the deceased from <u>Nov. 23, 1960</u> to <u>Feb. 11, 1961</u> that (d) (we) last saw the deceased alive on <u>Feb. 11, 1961</u> , and that death occurred <u>3:00AM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>M. Lawrence Rubin, M.D.</u>		22b. DATE SIGNED <u>2/12/61</u>		22c. ADDRESS <u>VAH, 3900 Loch Raven Blvd., Baltimore 18, Md. - Fort Howard Division</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-14-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Morgan Chapel Cemetery</u>	
23d. LOCATION (City, town or county) <u>Carroll Co., Maryland</u>		23e. (State) <u>Maryland</u>		23f. (City, town or county) <u>Woodbine</u>	
24. FURNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz</u>		24b. ADDRESS <u>Winfield, Maryland</u>		24c. P.O. <u>Sykesville, Maryland</u>	
25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thane</u>		DATE <u>FEB 14 '61</u>	

24 hours after death. The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2000



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

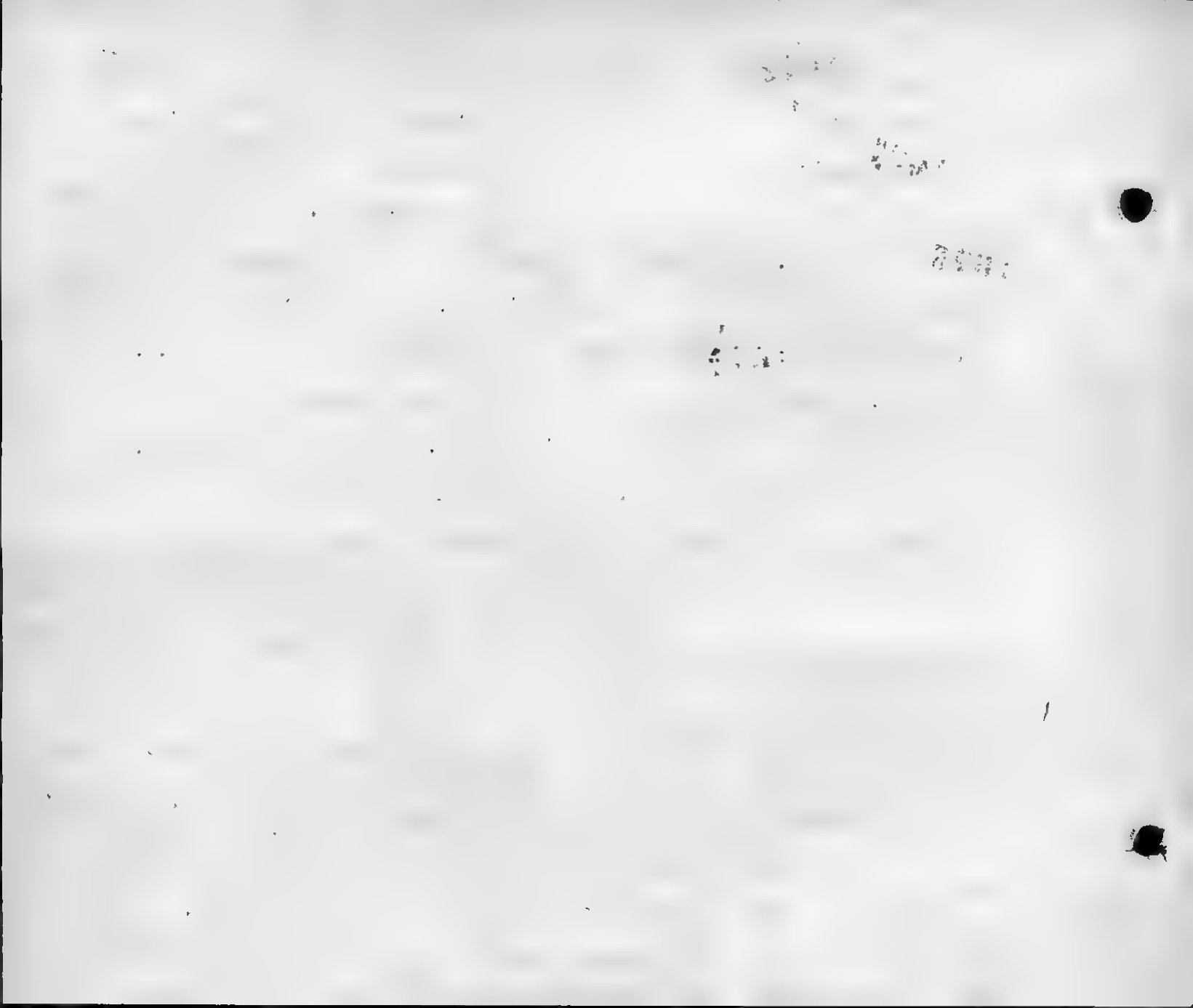
1672 CERTIFICATE OF DEATH

01652

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Residence</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>136 Newburg Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>E.</u> Middle <u>Gertrude</u> Last <u>Shipley</u>				4. DATE OF DEATH Month <u>February</u> Day <u>6</u> Year <u>1961</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 13, 1880</u>		9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Banking Company</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David E. Shipley</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Sandfox</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____				16. SOCIAL SECURITY NO. _____				17. INFORMANT Address _____ <u>Miss Mary A. Shipley 136 Newburg Ave. 28 Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Coronary occlusion</u> <u>420.1</u> DUE TO <u>Arteriosclerotic cardiovascular dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) _____								INTERVAL BETWEEN ONSET AND DEATH <u>1 day 1 y.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) _____				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED Where _____ Not White <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from Jan. 1961, to Feb. 1961, that (I) (we) last saw the deceased alive on Feb. 1961, and that death occurred at 11 P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Christian S. Mass</u> M.D.				22b. DATE SIGNED <u>2/7/61</u>							
22c. PHYSICIAN'S NAME (Type) <u>Christian S. Mass</u>				22d. ADDRESS <u>St. John's B'n. Center City</u>							
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>2-9-1961</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>				23d. LOCATION (City, town or county) <u>Baltimore</u> (State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Johnson Co</u>				ADDRESS <u>301 Frederick Road 28</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1673

01653

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CO.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital			d. STREET ADDRESS MIDDLE RIVER ROAD		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JOHN First LOUIS Middle SIMON Last			4. DATE OF DEATH FEBRUARY Month 25 Day 1961 Year		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 22, 1885	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) PIPE-MAKER			10b. KIND OF BUSINESS OR INDUSTRY MANUFACTURE BRICK		11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME AUGUST SIMON			14. MOTHER'S MAIDEN NAME MARY ROEDERGRADEN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)			16. SOCIAL SECURITY NO NOT KNOWN		
17. INFORMANT Hospital Records, Mt. Wilson State Hospital			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG 163 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) -- DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY TUBERCULOSIS 022 14 1/2 years duration					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home form, factory, street office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 01/1 1957 to 2-25 1961 , that (I) (we) last saw the deceased alive on 2-25 1961 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.					
22a. SIGNATURE W. Newcomer			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent			22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.		
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-28-1961	23c. NAME OF CEMETERY OR CREMATORY Zion Lutheran		23d. LOCATION (City, town, or county) (State) Golden Ring Rd. Balto. Co. Md.
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Fun. Home, Inc. Balto. 6, Md.			25a. REC'D BY REGISTRAR PTB 27 '61		
25b. REGISTRAR'S SIGNATURE Charles S. Kline					

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or inhumation, and in any event, within 72 hours after death.

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The first of these is the fact that the
 population of the United States is
 increasing at a rapid rate. This is
 due to a number of factors, including
 the fact that the birth rate is higher
 than the death rate, and the fact that
 the life expectancy is increasing.
 The second factor is the fact that
 the population is becoming more
 mobile. This is due to the fact that
 people are moving from rural areas to
 urban areas, and from the East to
 the West. This is due to a number of
 factors, including the fact that the
 economy is changing, and the fact that
 people are seeking better living
 conditions.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1674

CERTIFICATE OF DEATH

Reg. Dist. No.

01654

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rossville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rossville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pox 287 Ridge Rd.</u>				d. STREET ADDRESS <u>Box 287 Ridge Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Bertha Minnie Slater</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>24</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1891</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>Bernard L. Hasse</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmina Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Charles Slater</u> Address <u>Pox 287 Ridge Rd. 6</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>5 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetic Mellitus. Fracture Left Hip.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. <u>Jan 17</u> 19 <u>61</u> p. <u> </u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 17</u> , 19 <u>61</u> , to <u>Feb 24</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb 24</u> , 19 <u>61</u> , and that death occurred at <u>9:15 A. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J M Baumgardner</u> M.D.				ADDRESS (Street, city or town, state) <u>Balto 6 Md</u>		DATE SIGNED <u>2/24/61</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-28-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lacoch Funeral Home</u>				ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 27 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



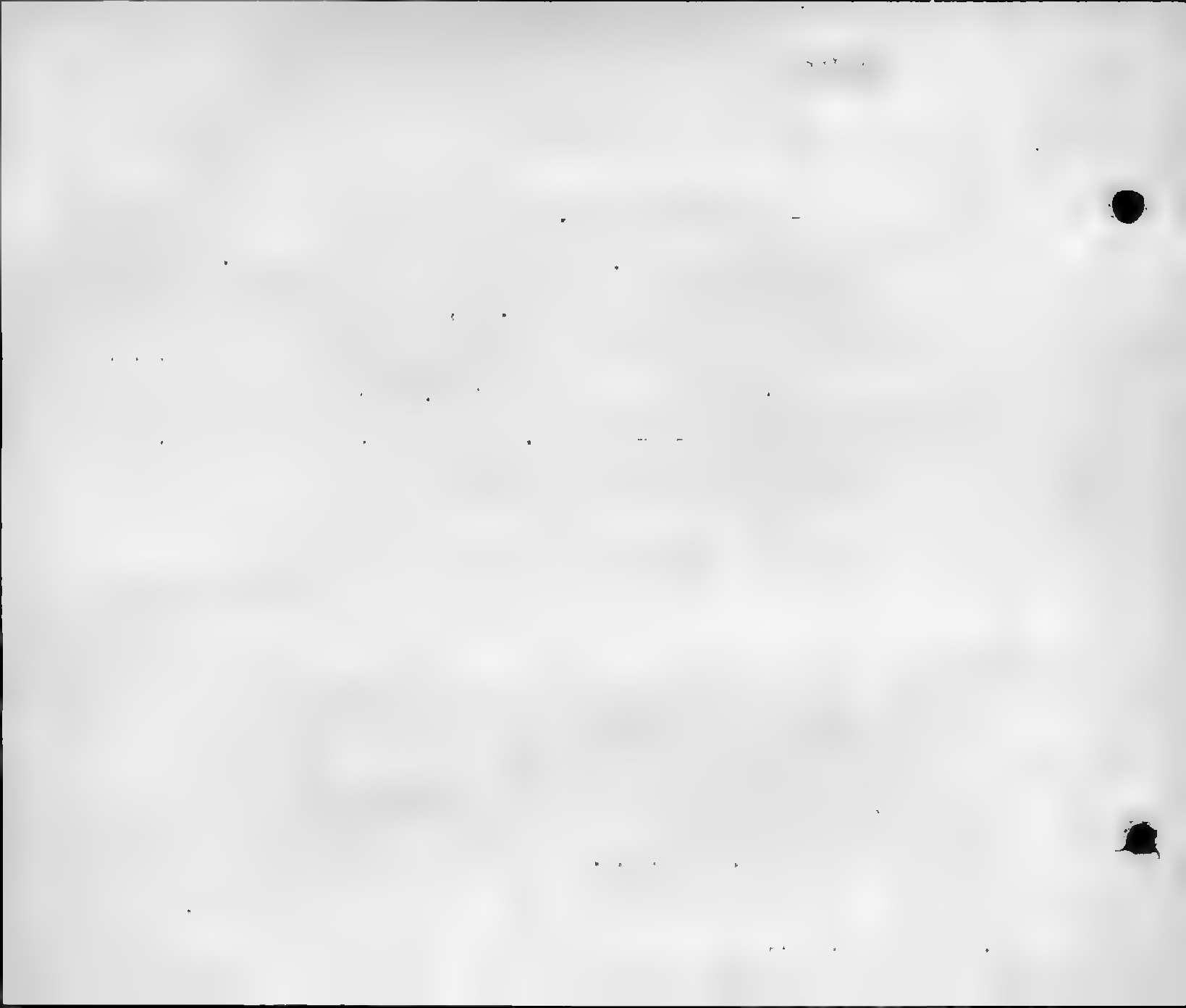
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FOR STATE
HEALTH DEPT

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1625 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01655

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years, last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE		DATE	



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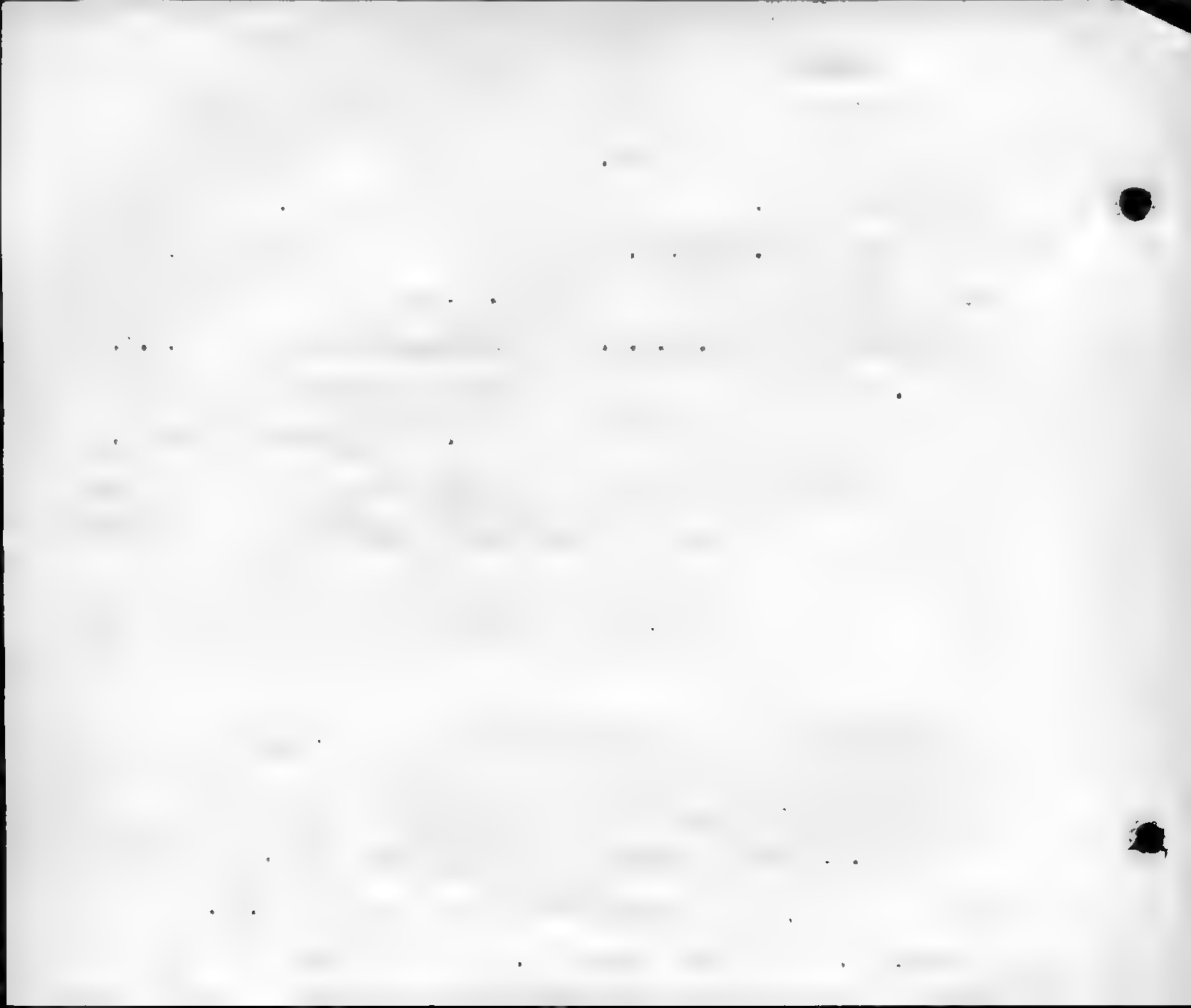
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1676

1656

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b 4 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5624 Braxfield Rd.		e. STREET ADDRESS 5624 Braxfield Rd.	
3 NAME OF DECEASED (Type or print) Franklin W. Smith, Sr.		4. DATE OF DEATH February 23, 1961	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 23, 1886
9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wreckmaster		10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.	
11. BIRTHPLACE (State or foreign country) Maryland Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis M. Smith		14. MOTHER'S MAIDEN NAME Virginia Schaefer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Louise M. Smith 5624 Braxfield Rd.	
17. INFORMANT Louise M. Smith		Address 5624 Braxfield Rd.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Unident.		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 10		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Nov 1, 1960 to Feb 23, 1961 , that (I) (we) last saw the deceased alive on Feb 23, 1961 , and that death occurred at 10 P. M., from the causes and on the date stated above			
22a. SIGNATURE A. Bradley Daugharthy		22b. ADDRESS 1264 Francis Ave.	
22c. PHYSICIAN'S NAME (Type) Dr. A. Bradley Daugharthy		22d. ADDRESS 1264 Francis Ave.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/27/61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ambrose, Inc. 1328 Sulphur Spring Rd.		25a. REC'D BY REGISTRAR DATE FEB 27 '61	
25b. REGISTRAR'S SIGNATURE W. H. Hines			



1677

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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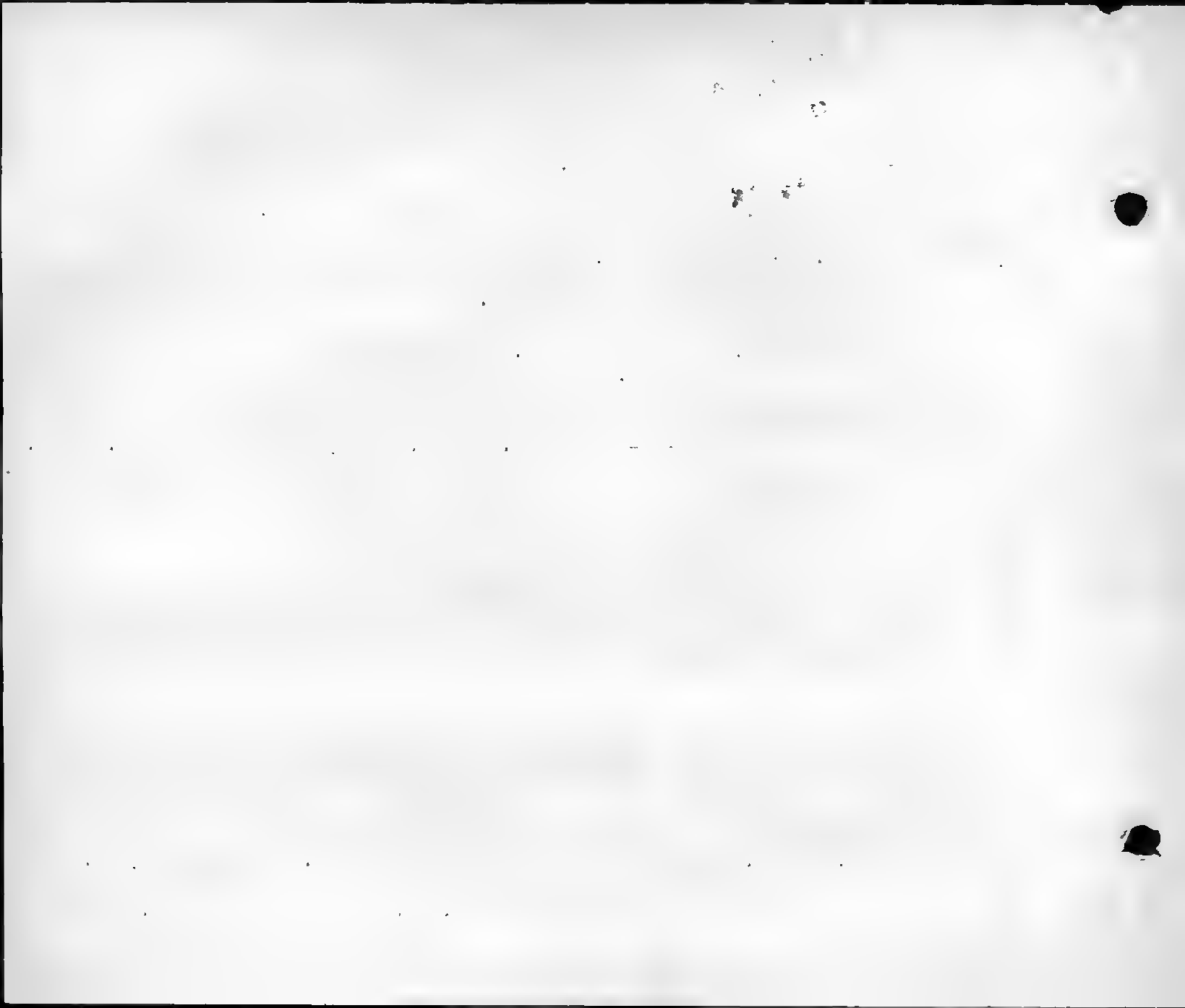
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Rockdale				c. LENGTH OF STAY IN 1b 12 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3104 Mayfield Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mr. Guy Middle E. Last Smith				4. DATE OF DEATH Month February Day 26 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 16, 1898	
9. AGE (In years last birthday) yrs 62		10. KIND OF BUSINESS OR INDUSTRY Transporation Dep't.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Smith Corp.				14. MOTHER'S MAIDEN NAME Bessie Rodgers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-2611		17. INFORMANT Address Mrs. Ruth E. Smith, 3104 Mayfield Ave. Balto. 7.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Failure of respiratory center 192-9 DUE TO (b) Extension of CNS malignancy to vital centers Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Primary CNS malignancy							INTERVAL BETWEEN ONSET AND DEATH 4-5 hours
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia, right.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 18, 1960 to Feb 26, 1961 , that (I) (we) last saw the deceased alive on Feb 24, 1961 , and that death occurred at 8 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE John J. Darrell				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. John J. Darrell				22d. ADDRESS 9017 Liberty Rd. Randallstown, Md.			
23a. BURIAL, CREMAT. OR REMOVAL (Specify) Burial		23b. DATE THEREOF March 1, 1961		23c. NAME OF CEMETERY OR CREMATORY Harbaugh Reform Ch. Cem.		23d. LOCATION (City, town, or county) (State) Rouzerville, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE Living Byers				ADDRESS 8728 Liberty Rd. Randallstown, Md.		25a. REC'D BY REGISTRAR DATE MAR 2 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the name of the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL: may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

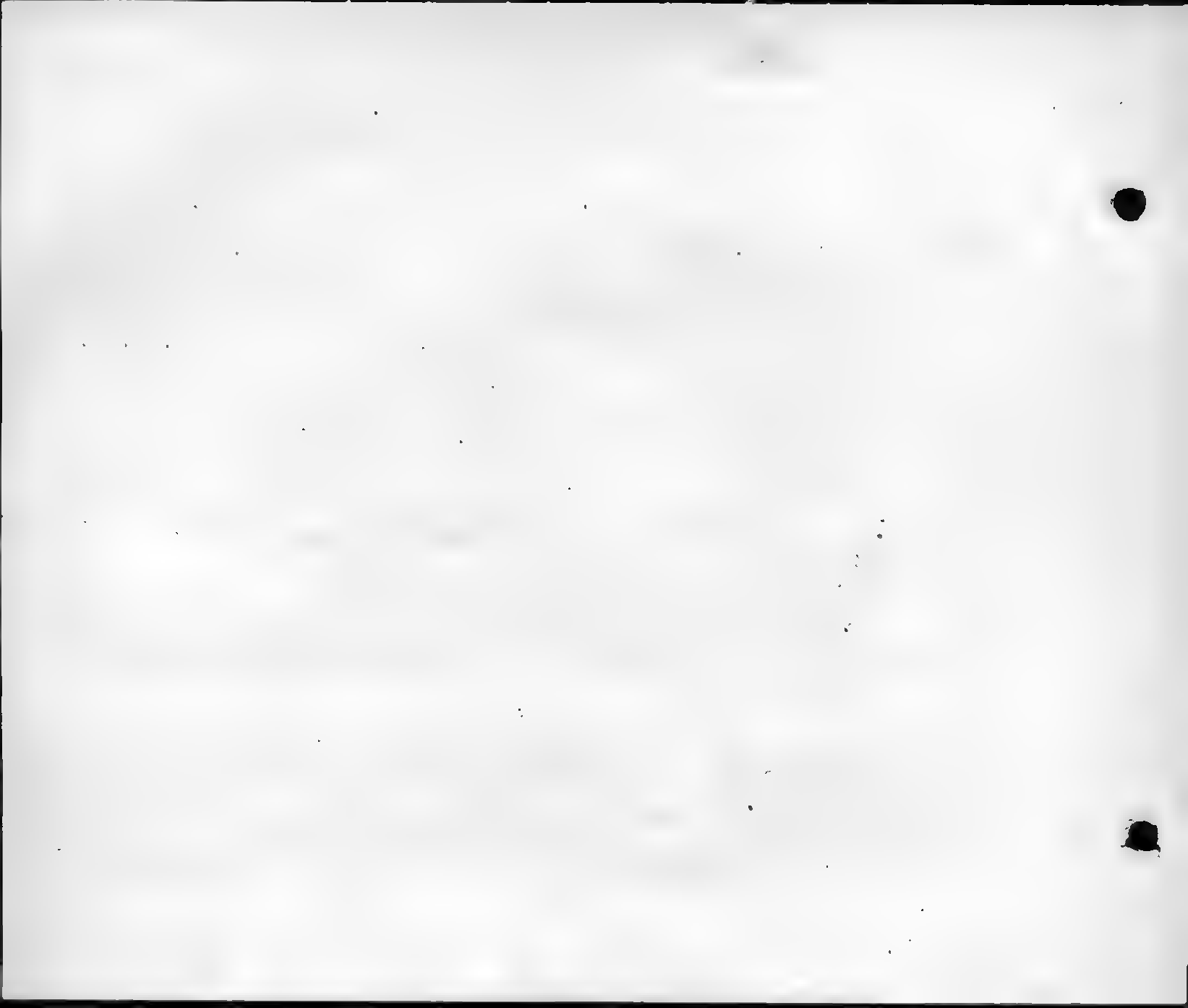


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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1678
CERTIFICATE OF DEATH

01658

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b X Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1007 Beechfield Ave.		e. STREET ADDRESS 1007 Beechfield Ave.	
3. NAME OF DECEASED (Type or print) EDITH C. SOPER First Middle Last		4. DATE OF DEATH Feb. 3, 1961 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ezekiel Niehoff		14. MOTHER'S MAIDEN NAME Maggie Gardner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Address Helen M. Soper, 1007 Beechfield Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mereuma</i> DUE TO (b) <i>Arterio-Sclerotic Cardiac Aneurysm</i> DUE TO (c) <i>Myocardial Infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/9/56 to 2/3/61, that (I) (we) last saw the deceased alive on 2/3/61, and that death occurred at 2 P.M. from the causes and on the date stated above			
22a. SIGNATURE Joseph E. Lawkaitis M.D.		22b. DTE SIGNED 2/4/61	
22c. PHYSICIAN'S NAME (Type) JOSEPH E. LAUKAITIS M.D.		22d. ADDRESS 6714 Washington Blvd - Baltimore	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/7/61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Howard H. Hubbard, 4107 Wilkens Ave		25a. RECEIVED BY REGISTRAR DATE FEB 6 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

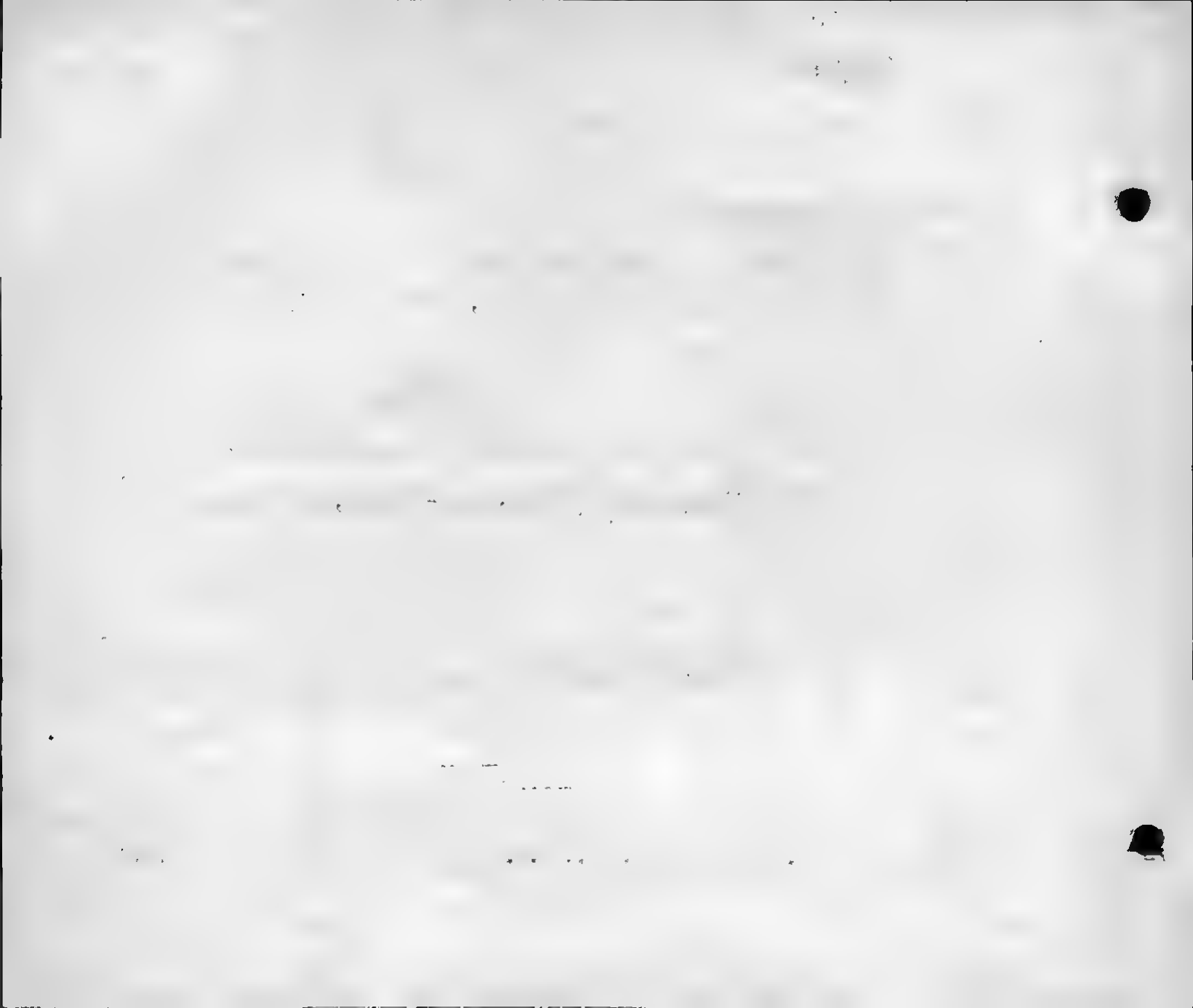
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1679 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01654

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN IT d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) York Road & Texas Lane		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks d. STREET ADDRESS X		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle FREDERICK Last SPRINKLE		4. DATE OF DEATH Month February Day 1 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 6, 1917		9. AGE (In years at birthday) 43 yrs		10. IF UNDER 1 YEAR: Months Days Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance foreman		10b. KIND OF BUSINESS OR INDUSTRY Baltimore County		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME George F. Sprinkle		14. MOTHER'S MAIDEN NAME Ida Viola Walters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) no		16. SOCIAL SECURITY NO. 212-40-5982		17. INFORMANT Mrs. Mary F. Sprinkle, Wheeler Lane, Sparks	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Apparently shot self in head 20c. TIME OF INJURY Month, Day, Year 2/1 1961 Hour a.m. 6:15 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Repair shop 20f. (City or town) (County) (State) Sparks Baltimore Md.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/1/61	
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.		Address (Street, city, town, or county) Carroll County, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/4/61		22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial	
22d. LOCATION (City, town, or county) (State) Carroll County, Md.		23. FUNERAL DIRECTOR Wm. Cook-Towson, Inc., 1050 York Rd., Towson 4,		24a. REC'D BY REGISTRAR FEB 6 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Howard					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1680

1660

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

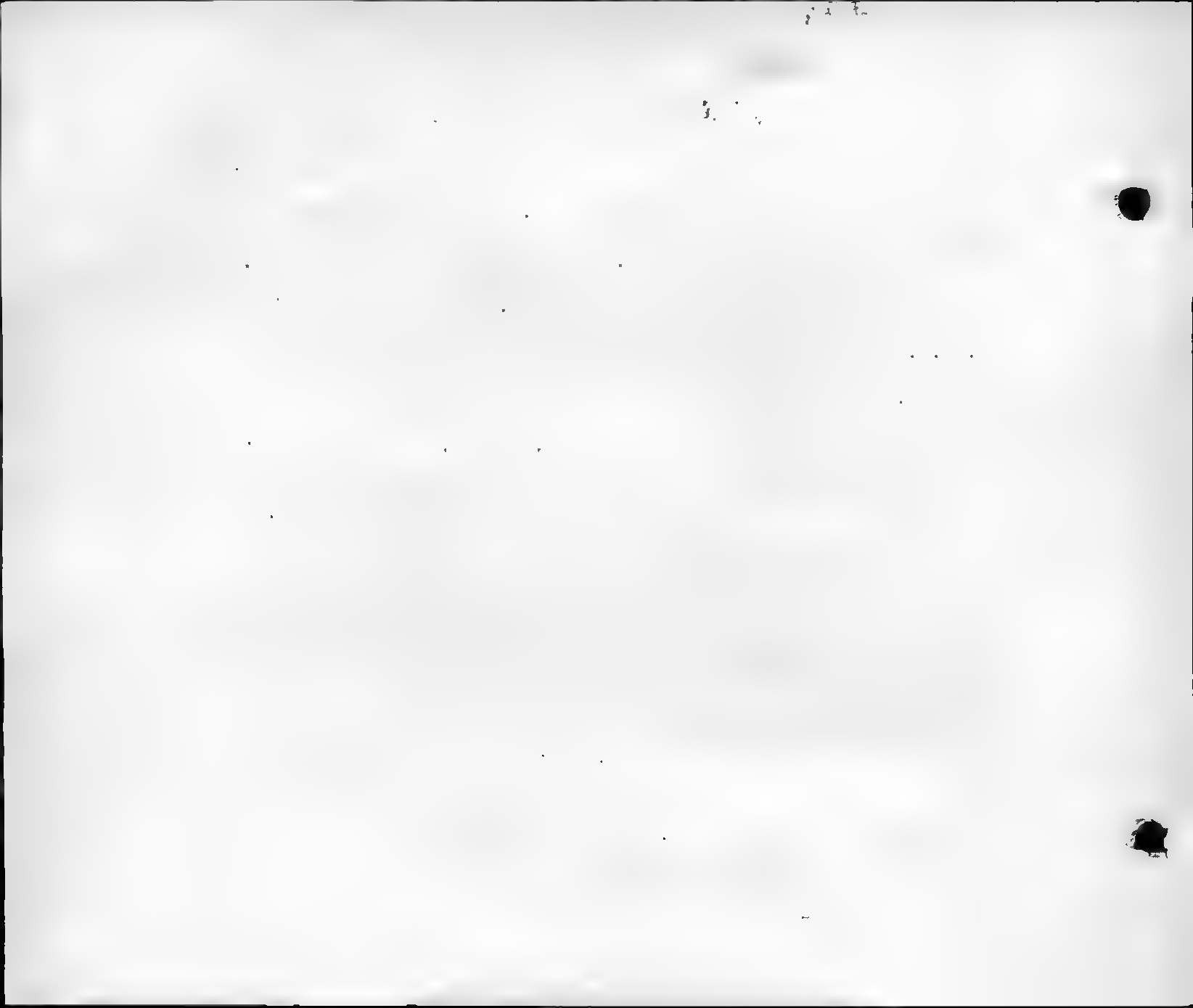
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton, Maryland Seat Pleasant, Md.	
c. LENGTH OF STAY IN 1b 1 mth 14 dys		d. STREET ADDRESS 622 Addison Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles A. Stephenson		4. DATE OF DEATH February 7 1961	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1894	
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Wash. Gas Light Co	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles W. Stephenson		14. MOTHER'S MAIDEN NAME Annie R. Mullikin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Arteriosclerotic cardiovascular disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 22, 1960 to Feb. 7, 1961, that (I) (we) last saw the deceased alive on Feb. 7, 1961, and that death occurred at 4:55 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 2-7-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-10-61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) (State) Suitland Md	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Beis		25a. REC'D BY REGISTRAR 1661 GOOD HOPE RD. SE WASH DC	
25b. REGISTRAR'S SIGNATURE Charles S. Kraus		25c. DATE FEB 8 '61	

1681

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01661

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY L...			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armcast Nursing Home-812 Regester Ave.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Rogers Forge) STREET ADDRESS 217 Murdock Road			
4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Le Roy Middle L. Last Stump				4. DATE OF DEATH Month Feb. Day 9 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 17, 1888	
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min.		11. IF UNDER 24 HRS Months 72 Days 72 Hours 72 Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. F.H. Durkee Enterprises				10b. KIND OF BUSINESS OR INDUSTRY Accountant			
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Henry J. Stump				14. MOTHER'S MAIDEN NAME Mary Dodd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Reba S. Stump- 217 Murdock Road				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 154X DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 1 (c)				INTERVAL BETWEEN ONSET AND DEATH 5 yrs			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 1961 to Feb 9, 1961 , that (I) (we) last saw the deceased alive on Feb 9, 1961 , and that death occurred at 5 M, from the causes and on the date stated above.							
22a. SIGNATURE Paul Byerly				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Paul Byerly				22d. ADDRESS 30336 ...			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2-11-61			
23c. NAME OF CEMETERY OR CREMATORY Finksburg				23d. LOCATION (City, town, or county) (State) Finksburg, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. ...				25a. REC'D BY REGISTRAR DATE FEB 14 '61			
25b. REGISTRAR'S SIGNATURE ...				25c. REGISTRAR'S SIGNATURE ...			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

News

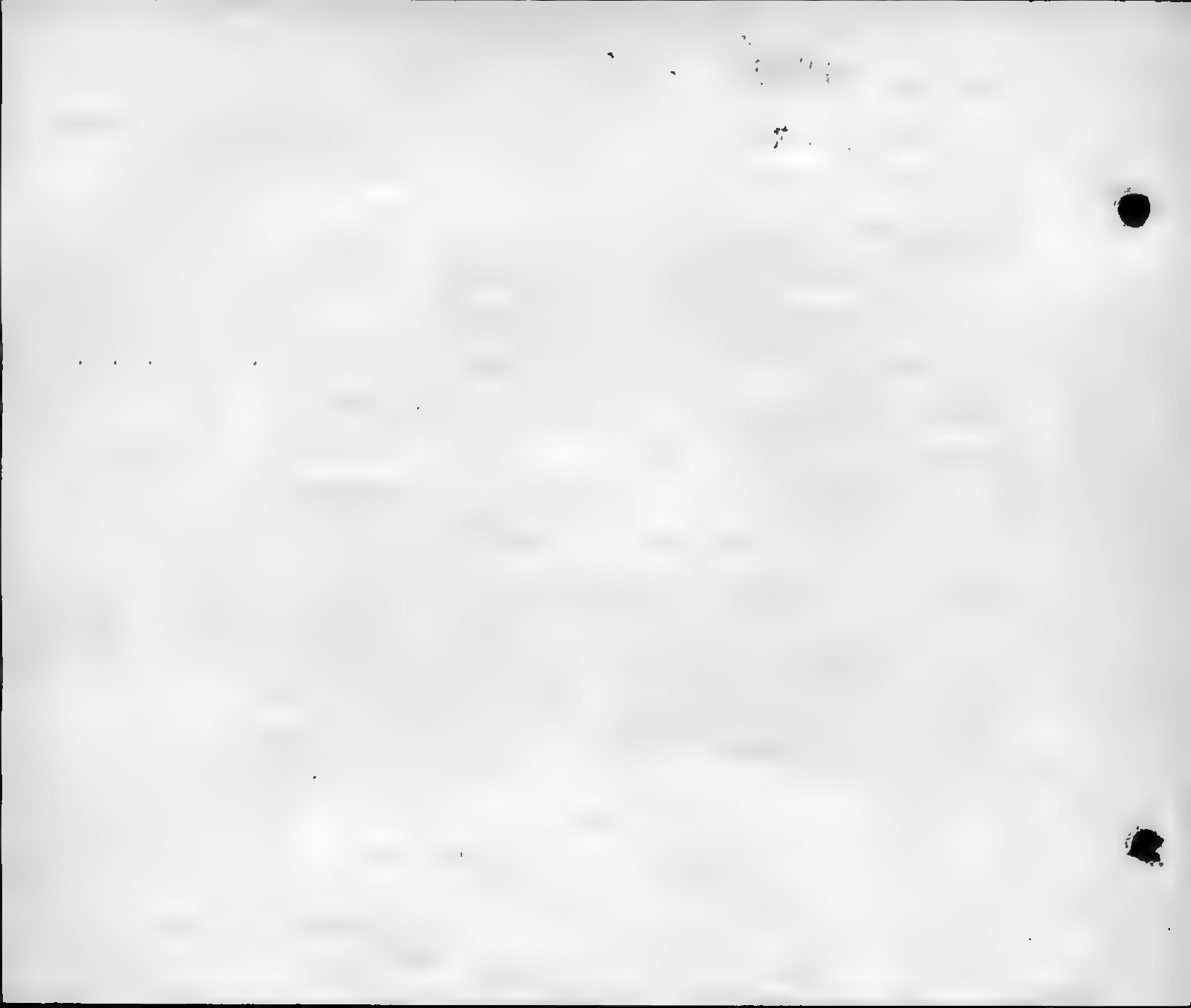
1

1682

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01662

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN TB 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Washington D.C. b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Edward Sylvester		4. DATE OF DEATH Month 2 Day 20 Year 19 61	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/2/60 9. AGE (In years last birthday) yrs. 5 Months 18 IF UNDER 1 YEAR IF UNDER 24 HRS. Hours 5 Min 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 10b. KIND OF BUSINESS OR INDUSTRY none 11. BIRTHPLACE (County & State, or foreign country) Whe Washington, D. C. 12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Ernest Sylvester 14. MOTHER'S MAIDEN NAME Betty J. Goodnow	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none 17. INFORMANT Rosewood Records, Owings Mills Address none		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of stomach content, massive 3 4 4 X DUE TO Conditions, if any, which gave rise to immediate cause (b) infected hydrocephalus (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH	
21. I certify that (I) (this hospital) attended the deceased from 2/15 , 19 61 to 2/20 , 19 61 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 9:20, from the causes and on the date stated above.		22a. SIGNATURE W. Rieckert, Pathologist M.D. 22b. DATE SIGNED 2-20-61 22c. PHYSICIAN'S NAME (Type) Peter W. Rieckert 22d. ADDRESS 4307 Mainfield Ave, Balb 14	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Feb. 23 1961 23c. NAME OF CEMETERY OR CREMATORY Rosewood 23d. LOCATION (City, town or county) (State) Owings Mills		24. FUNERAL DIRECTOR'S SIGNATURE J. F. Elmer Sons ADDRESS Reisterstown Md. 25a. REC'D BY REGISTRAR FEB 27 1961 25b. REGISTRAR'S SIGNATURE Charles E. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

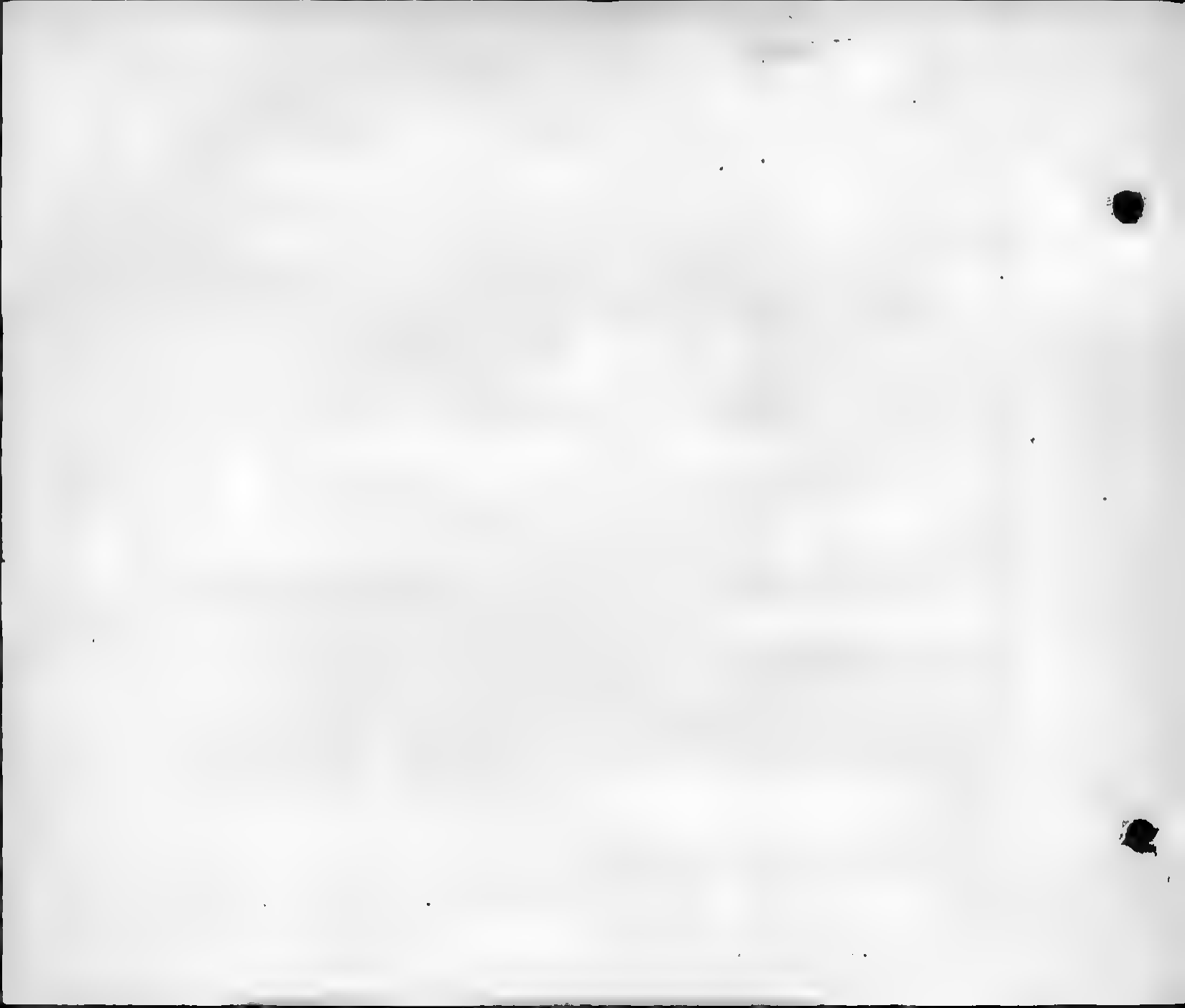
1683

CERTIFICATE OF DEATH

Reg. Dist. No. 01663

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>1 year</u>				d. STREET ADDRESS <u>3620 Roland Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Masonic Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Charlotte</u> Last <u>Thorne</u>				4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/31/1888</u>	
9. AGE (In years last birthday) <u>72</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>William J. Cameron</u>		14. MOTHER'S MAIDEN NAME <u>Harriet J. Stiller</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>216-10-76160</u>		17. INFORMANT <u>Kathryn Thompson R.N. Cockeysville</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arterio Sclerotic Cardio Vascular Disease</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>Over 1 year</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-20, 1960</u> to <u>2-21, 1961</u> , that I last saw the deceased alive on <u>2-20, 1961</u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cockeysville, Md.</u> DATE SIGNED <u>2/21/61</u>							
ACTUAL SIGNATURE <u>Walter T. Rees</u>				PHYSICIAN'S NAME (Type) <u>Walter T. Rees</u>			
22a. BURIAL, CREMATION, BURIAL (Specify)		22b. DATE THEREOF <u>2-24-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Methodist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Freeland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Zone 2</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 23 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be re- by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

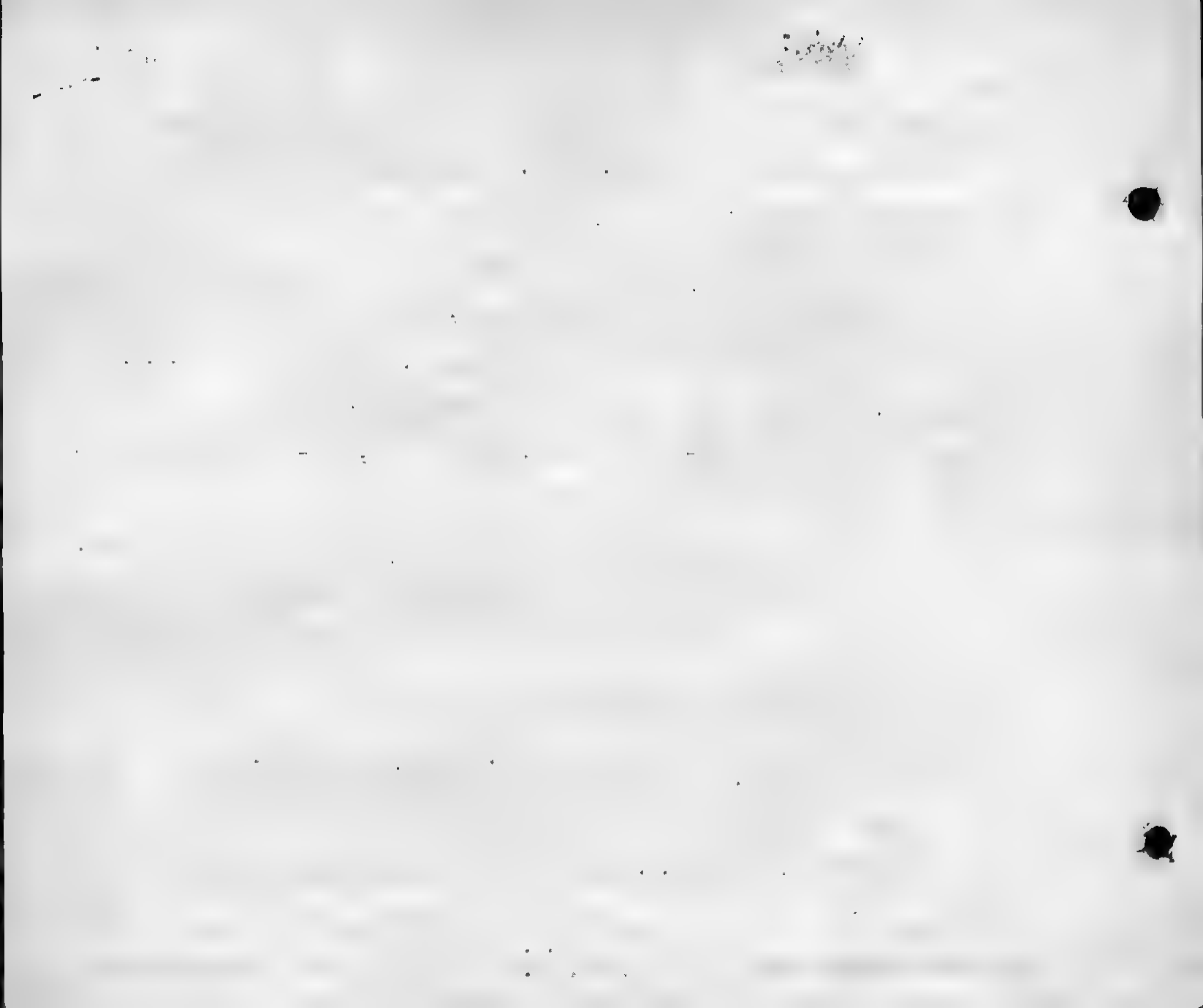
1684

CERTIFICATE OF DEATH

01664

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Fort Howard, Maryland</u> c. LENGTH OF STAY in b. <u>21 Hrs. 40min.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>22 Leymar Road</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> Served AS: <u>Elmer</u> (Type or print) <u>JOHN</u> <u>M</u> <u>E</u>		4. DATE OF DEATH Month <u>February</u> Day <u>4</u> Year <u>1961</u> TOWERS TOWERS	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 14, 1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>14</u> Hours <u>14</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Engineer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Whiting + Turner</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William G. Towers</u>		14. MOTHER'S MAIDEN NAME <u>Adeline Montague</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW-1</u>		16. SOCIAL SECURITY NO. <u>215-03-0486</u> 17. INFORMANT <u>VAH, Baltimore 18, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EDEMA OF LUNGS</u> DUE TO (b) <u>CARDIAC INSUFFICIENCY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>EPIDERMOID CARCINOMA OF THE LEFT LUNG</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 mos.</u> <u>1 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>M</u> (this hospital) attended the deceased from <u>Feb. 3</u> to <u>Feb. 4</u> , 1961, that <u>W</u> (we) last saw the deceased alive on <u>Feb. 4</u> , 1961, and that death occurred at <u>A</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph J. Cillo M.D.</u>		22b. DATE SIGNED <u>Feb. 4, 1961</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>JOSEPH J. CILLO, M.D.</u>		22d. ADDRESS <u>VAH, Fort Howard, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 4, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Singleton Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u> 25b. REGISTRAR'S SIGNATURE <u>DATE FEB 7 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and any event within 72 hours after death.

1
 1685
 01665
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix (rural)			
c. LENGTH OF STAY IN 1b 2 yrs.				d. STREET ADDRESS Phoenix, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Haven Nursing Home Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary A. C. Trapp				4. DATE OF DEATH Month Day Year 2 - 8 - 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-19- 1877	
9. AGE (In years last birthday) 83 yrs		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Trapp				14. MOTHER'S MAIDEN NAME Annie Gantner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Frederick G. Trapp 2302 Boston St #24			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIO - VASCULAR DISEASE DUE TO CARDIAC ARREST (b) CARDIAC ARREST DUE TO CARDIAC ARREST (c) CARDIAC ARREST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 10/19 1958 to 2/8 1961 , that (I) (we) last saw the deceased alive on 2/5 1961 , and that death occurred 2/8 1961 from the causes and on the date stated above.							
22a. SIGNATURE John H. Shaw M.D.				22b. ADDRESS 5800 EMMERSON AVE. BALTIMORE		22c. DATE SIGNED 2/9/61	
22c. PHYSICIAN'S NAME (Type) John H. Shaw							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-11-61		23c. NAME OF CEMETERY OR CREMATORY St. Johns, Blenheim		23d. LOCATION (City, town, or county) (State) Phoenix, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.				25a. REC'D BY REGISTRAR FEB 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

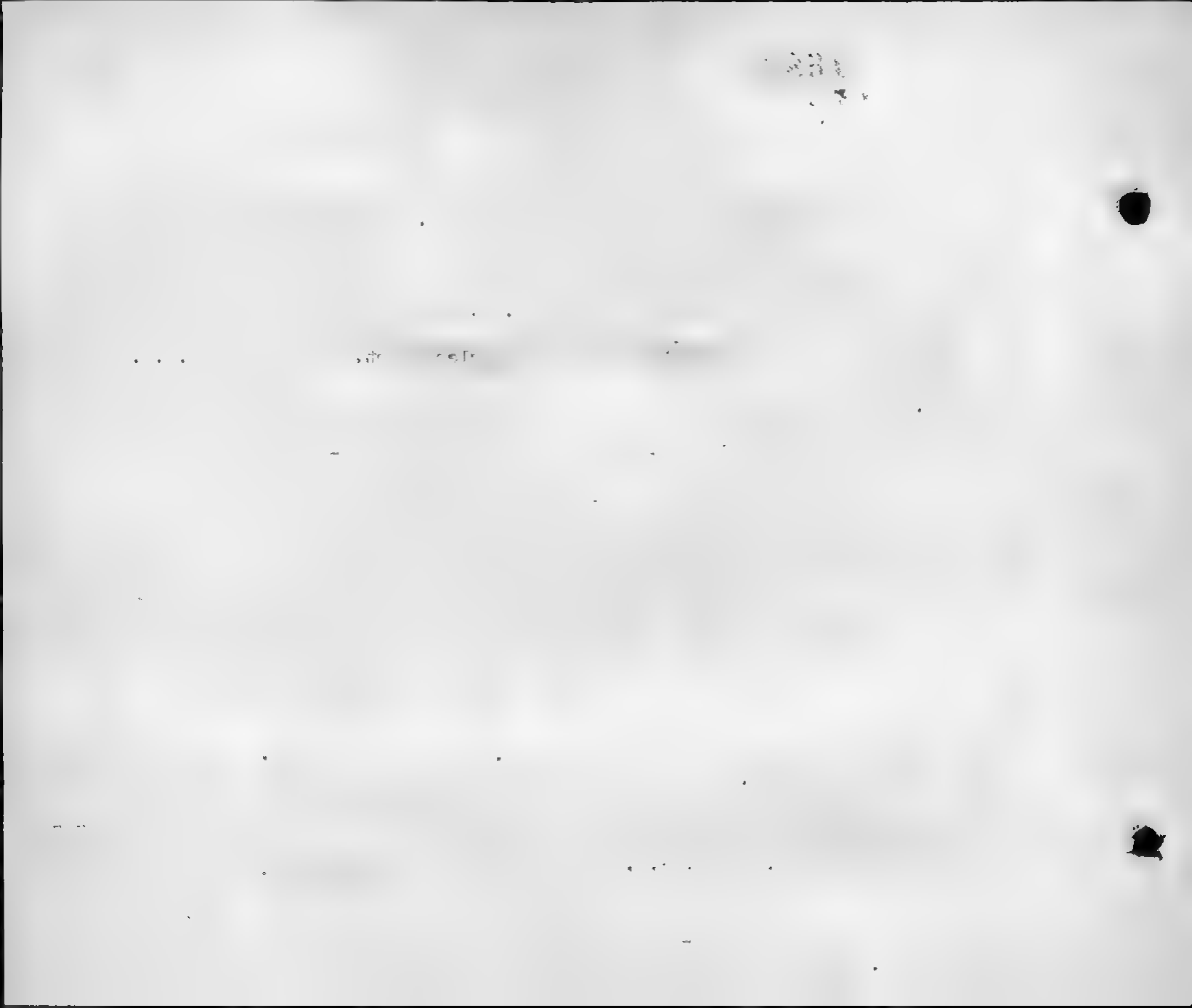
VR A15 (4)
15M 9/60

(M)

(I)

MEDICAL CERTIFICATION

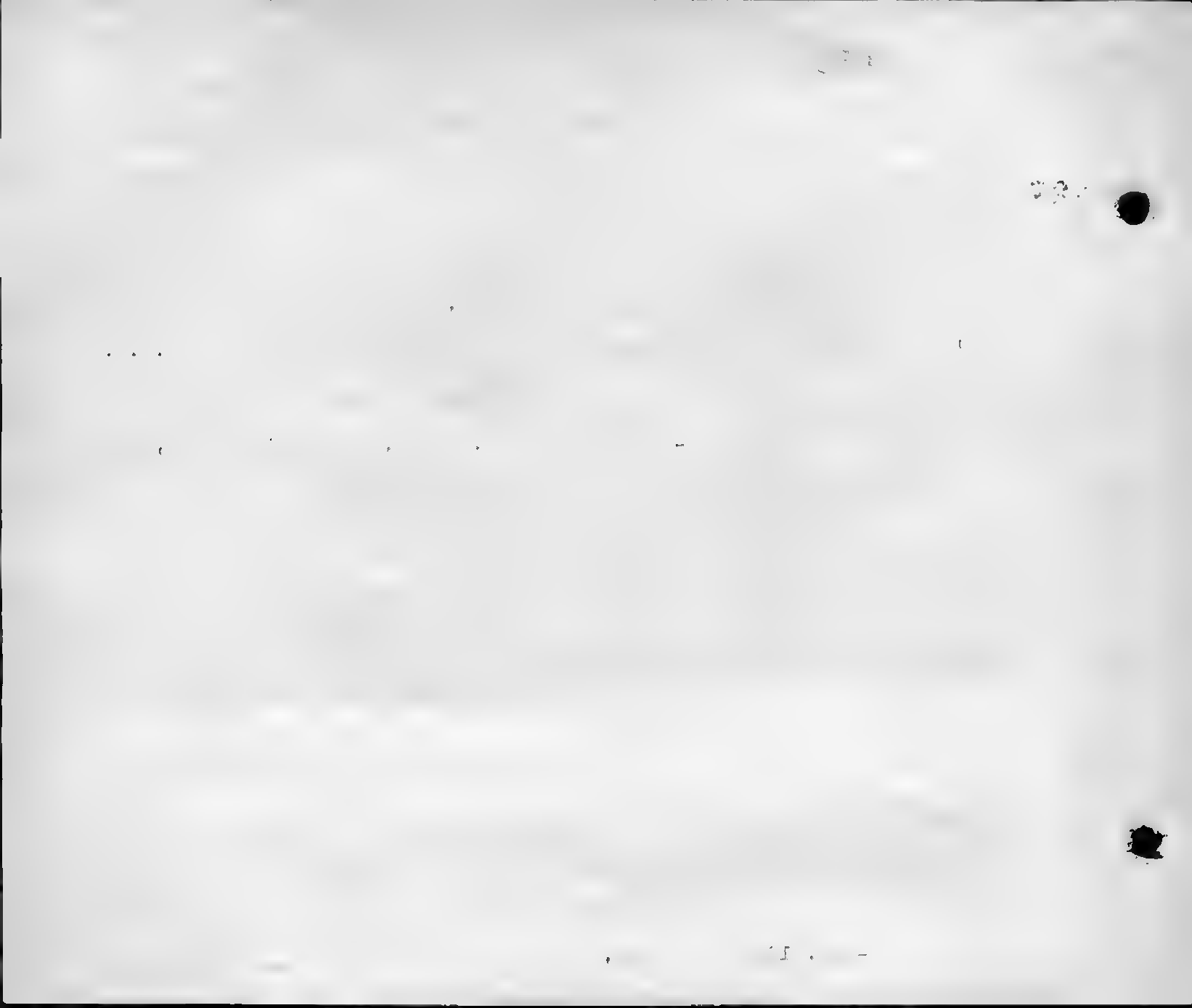
MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
1686																			
01666																			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town.) <u>Fort Howard</u> c. LENGTH OF STAY IN lb <u>44 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>					2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Baltimore 15</u> d. STREET ADDRESS <u>2412 W. Cold Spring Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <u>JAMES H. TURNER</u>					4. DATE OF DEATH February 4, 1961														
5. SEX <u>Male</u> 6. COLOR <u>Negro</u>					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>														
8. DATE OF BIRTH <u>Feb. 2, 1878</u>					9. AGE (In years last birthday) <u>83</u> yrs.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Women's Medical College</u>														
11. PLACE <u>Charles County Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>														
13. FATHER'S NAME <u>John W. Turner</u>					14. MOTHER'S MAIDEN NAME <u>Eliza Toyer</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year and dates of service) <u>Yes</u> <u>SAW</u>					16. SOCIAL SECURITY NO <u>185-01-1409</u>														
17. INFORMANT <u>Clinical Records</u>					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>MASSIVE GASTRO-INTESTINAL TRACT HEMORRHAGE</u> DUE TO (b) <u>RUPTURED AORTIC ARTERIOSCLEROTIC ANEURYSM INTO 3RD PORTION OF THE DUODEUM</u> (c) <u>MULTIPLE MYELOMA</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last														
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>3 DAYS</u> <u>3 YEARS</u>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>GENERALIZED ARTERIOSCLEROSIS</u>																			
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>										20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>VAH Fort Howard, Md.</u>										20d. (City or town) (County) (State)									
21. I certify that <u>X</u> (this hospital) attended the deceased from <u>Dec. 22, 1960</u> to <u>Feb. 4, 1961</u> , that <u>X</u> (we) last saw the deceased alive on <u>Feb. 4, 1961</u> , and that death occurred at <u>A M</u> , from the causes and on the date stated above.										22a. SIGNATURE <u>Arthur T. Faulk</u> 22b. DATE SIGNED <u>2-5-61</u>									
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR T. FAULK, M.D.</u>										22d. ADDRESS <u>VAH Fort Howard, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>										23b. DATE THEREOF <u>2/8/61</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>										23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips</u>										25a. REC'D BY REGISTRAR <u>Baltimore 17 Maryland</u>									
25b. REGISTRAR'S SIGNATURE <u>Feb 10 '61</u>										25c. DATE <u>Feb 10 '61</u>									



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND											
1687 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01667											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville							
c. LENGTH OF STAY IN lb				d. STREET ADDRESS 30 Tenbury Road							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 30 Tenbury Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CAMILLO				4. DATE OF DEATH February 7 19 61				5. SEX male			
6. COLOR OR RACE white				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH July 20, 1890			
9. AGE (In years last birthday) 70				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (ret'd) Tailor				11. BIRTHPLACE (State or foreign country) Italy			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Francesco Vanni				14. MOTHER'S MAIDEN NAME Filumena Sabina			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-09-5574				17. INFORMANT Anita V. Vitale, 5103 Harford Road, "one 14"			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles F. O'Donnell M.D.											
EXAMINER'S NAME (Type) Charles F. O'Donnell											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL											
22b. DATE THEREOF 2-11-61											
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery											
22d. LOCATION (City, town, or country) (State) Baltimore											
23. FUNERAL DIRECTOR ADDRESS William Cook-Inc., 1050 York Road, Zone 4											
24a. REC'D BY REGISTRAR DATE FEB 10 '61											
24b. REGISTRAR'S SIGNATURE C. L. S. Kraus											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1688

01668

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 30 d. STREET ADDRESS 1458 Battery Avenue	
3. NAME OF DECEASED (Type or print) GEORGE Male White Laborer John G. Vogel		4. DATE OF DEATH February 6 1961 May 15, 1891 169 1458 Battery Avenue Baltimore, Maryland U. S. A.	
5. SEX Male White Laborer		6. COLOR OR RACE White Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> May 15, 1891 169 1458 Battery Avenue Baltimore, Maryland U. S. A.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> May 15, 1891 169 1458 Battery Avenue Baltimore, Maryland U. S. A.		8. DATE OF BIRTH May 15, 1891 169 1458 Battery Avenue Baltimore, Maryland U. S. A.	
9. AGE (In years last birthday) 69 1458 Battery Avenue Baltimore, Maryland U. S. A.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer John G. Vogel	
11. BIRTHPLACE (Country & State, or foreign country) Baltimore, Maryland U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John G. Vogel		14. MOTHER'S MAIDEN NAME Rosie M. McCune	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 212-16-8299	
17. INFORMATION 212-16-8299		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] ARTERIO SCLEROSIS OF THE AORTIC VALVE CARDIAC DECOMPENSATION EDEMA OF LUNGS	
19. STATUS POST GASTROENTEROSTOMY FOR PYLORIC OBSTRUCTION		20. STATUS POST GASTROENTEROSTOMY FOR PYLORIC OBSTRUCTION	
21. I certify that (X (this hospital) attended the deceased from November 28, 1960 , to February 6, 1961 , that (we) last saw the deceased alive on February 6, 1961 , and that death occurred at 1:45 A.M., from the causes and on the date stated above.		22. DATE PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE ERNEST O. BROWN, M.D.		22b. DATE 2/6/61	
22c. PHYSICIAN'S NAME (Type) ERNEST O. BROWN, M.D.		22d. ADDRESS VAH BALTIMORE MD - FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-9-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto.		25a. REC'D BY REGISTRAR DATE FEB 8 '61	
25b. REGISTRAR'S SIGNATURE Clara E. Hume		25c. DATE FEB 8 '61	

14, Md.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

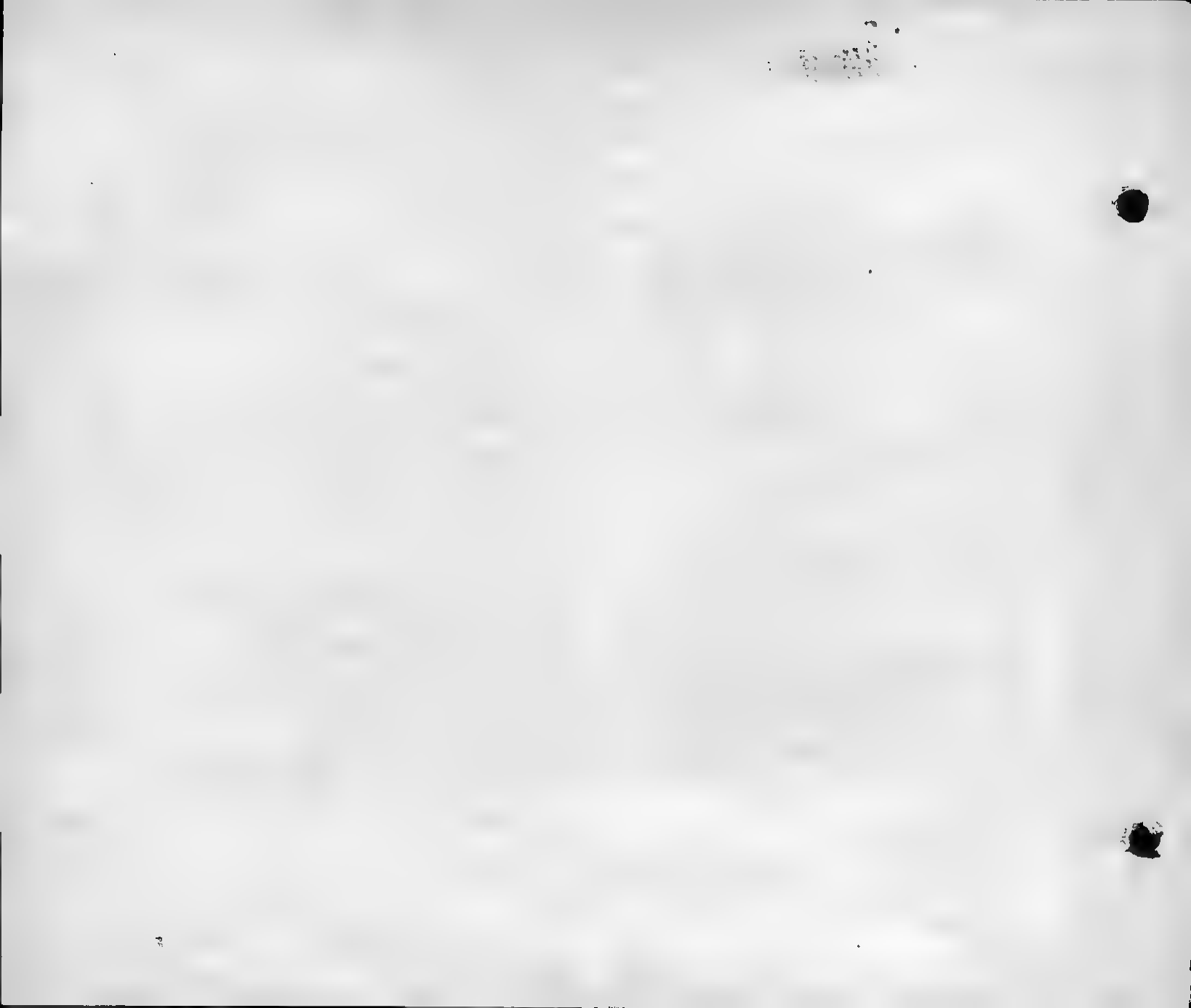
VS. A15ME
SM 7/59

1
FOR STATE
HEALTH DEPT.

M

MEDICAL CERTIFICATION

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
168 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
01669											
1. PLACE OF DEATH a. COUNTY <u>Balti.</u>				2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence and admission) a. STATE <u>Md.</u> b. COUNTY <u>Balti.</u>							
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Pineville 8</u>				c. LENGTH OF STAY IN 1b <u>20 yrs.</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pineville 8</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pennona estate</u>				d. STREET ADDRESS <u>Pennona estate</u>				a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print, First Middle Last) <u>LEVI ANDREW WALLACE</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>27</u> Year <u>1961</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucas.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr 1, 1932</u>		9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trailer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Print. House</u>				11. BIRTHPLACE (State or foreign country) <u>Williamburg, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Wm. Wallace</u>				14. MOTHER'S MAIDEN NAME <u>Mary Cook</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-18-9634</u>				17. INFORMANT <u>Hagelle Wallace (wife)</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>422.1</u> DUE TO (b) <u>arteriosclerotic C. & Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) <u>chronic</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>2 yrs.</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>chronic</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7:00</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> No While at work <input type="checkbox"/> <u>Private</u>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) _____			
20f. (City or town) _____ (County) _____ (State) _____											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2-27-61</u>											
ACTUAL SIGNATURE <u>D. D. Catle</u> M.D.											
EXAMINER'S NAME (Type) <u>D. D. CATLES</u>				Address (Street, city, town, or county) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/3/61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>			
22d. LOCATION (City, town, or country) (State) <u>Beth Md</u>											
23. FUNERAL DIRECTOR <u>Marjorie P. Hays 638 p. Glenwood St</u>				24a. REC'D BY REGISTRAR <u>FEB 28 '61</u>				24b. REGISTRAR'S SIGNATURE <u>John S. Hark</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1690

CERTIFICATE OF DEATH

Reg. Dist. No. 1670

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before adm ss on) a. STATE MD b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Budwood Sanatorium Towson 4, Maryland		d. STREET ADDRESS 1832 Yakona Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ralph First H. Middle Walston Last		4. DATE OF DEATH Month 2 Day 23 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 11, 1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Nipple Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Luther Walston		14. MOTHER'S MAIDEN NAME Fanny Blake	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 216-09-4277	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lungs - 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 11/11	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-10 , 19 60 , to 2-23 , 19 61 , that I last saw the deceased alive on 2-23 , 19 61 , and that death occurred at 3:30 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Arthur B. Kues MD Eudowed 2-23-61			
ACTUAL SIGNATURE Arthur B. Kues		PHYSICIAN'S NAME (Type) Eudowed	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-27-61	
22c. NAME OF CEMETERY OR CREMATORY MORELAND PARK		22d. LOCATION (City, town, or county) (State) PARKVILLE MD	
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM FUNERAL HOME		ADDRESS 4210 Belair MD	
24a. REC'D BY REGISTRAR 2-27-61		24b. REGISTRAR'S SIGNATURE Arthur B. Kues	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, the certificate should be executed by the Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1691

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01671

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN IL <u>6 Wks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eastspring RD</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>1408 Eastspring RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MILTON RUSSELL WARRICK</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>12</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>6-18-14</u>		9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>12</u> Hours <u>1</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ADJUSTER</u>		12. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>		13. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
14. FATHER'S NAME <u>Homer Warrick</u>		15. MOTHER'S MAIDEN NAME <u>Fern Bingham</u>		16. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		18. SOCIAL SECURITY NO. <u>????</u>		19. INFORMANT <u>Elizabeth Warrick, above</u>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>DIABETES MELLITUS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>William A Pillsbury</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WILLIAM A PILLSBURY</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2/12/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-16-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda</u>	
22d. LOCATION (City, town, or country) <u>Brownsburg, Indiana</u>		22e. REC'D BY REGISTRAR <u>Arthur L. Hume</u>			
23. FUNERAL DIRECTOR <u>Brooks Funeral Service, Towson 4, Md.</u>		24. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

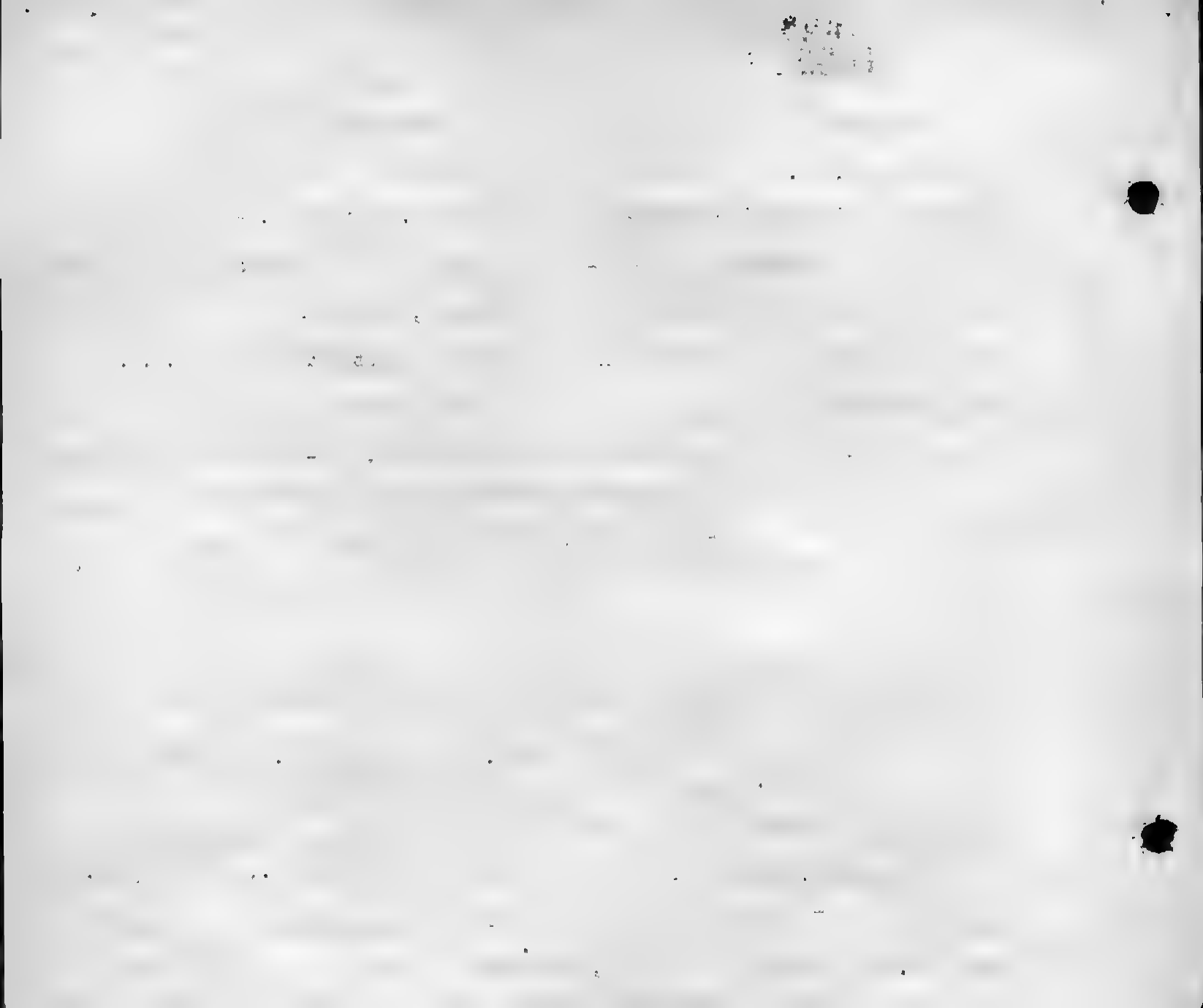
1692

CERTIFICATE OF DEATH

01672

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY (in days) 42 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2848 W. Lanvale St. -16 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANDREW First Middle Last WATERS				4. DATE OF DEATH February 15 1961 Month Day Year			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Chemical Plant		8. DATE OF BIRTH September 2, 1896 Day Month Year			
11. BIRTHPLACE (County & State, or foreign country) Winnsboro, South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Preston Waters				14. MOTHER'S MAIDEN NAME Martha Davis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-1 (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 215-09-6391			
17. INFORMANT Clinical Records				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, ATELECTASIS & BRONCHIECTASIS RIGHT LUNG DUE TO (b) SQUAMOUS CELL CARCINOMA OF THE RIGHT LUNG (c) METASTATIC CARCINOMA ESOPHAGUS WITH PERFORATION XXX c. METASTATIC CARCINOMA LYMPH NODES			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 4 1961 to Feb. 15 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 15 1961 , and that death occurred at 5 P.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Thomas F. Crahan</i> THOMAS F. CRAHAN, M.D.				22b. DATE SIGNED Feb. 20 1961			
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.				22d. ADDRESS VA Hospital Fort Howard Division 3900 Loch Raven Blvd., Balto 18, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-20-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i> Charles R. Law Mortuary		25a. REC'D BY REGISTRAR 802 Madison Ave. Baltimore, Maryland 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Knecht</i> FEB 20 1961					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



may be returned by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1693

01673

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2922 Liberty Parkway		d. STREET ADDRESS 2922 Liberty Parkway	
3. NAME OF DECEASED (Type or print) First Middle Last MILTON E. WEBSTER		4. DATE OF DEATH Month Day Year February 25, 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1879
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. BIRTHPLACE (State or foreign country) Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler maker		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George A. Webster		14. MOTHER'S MAIDEN NAME Cornelia White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Melvin E. Webster		Address 2922 Liberty Parkway	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) A-S-C-V-E-I 422.1 DUE TO Security Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholera - 2 specimens 3 specimens			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 19, 1961 to Feb 25, 1961 that (I) (we) last saw the deceased alive on Feb 25, 1961 and that death occurred at 6:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE M.B. Davis		22b. DATE SIGNED 2/27/61	
22c. PHYSICIAN'S NAME (Type) M.B. Davis, M.D.		22d. ADDRESS 6800 Maryland Ave Dundalk, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 28, 1961	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION (City town or county) (State) Woodlawn, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home, Dundalk, Md.		25. REC'D BY REGISTRAR DATE MAR 1 '61	
25b. REGISTRAR'S SIGNATURE Curtis S. Howard			

IVI

I



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

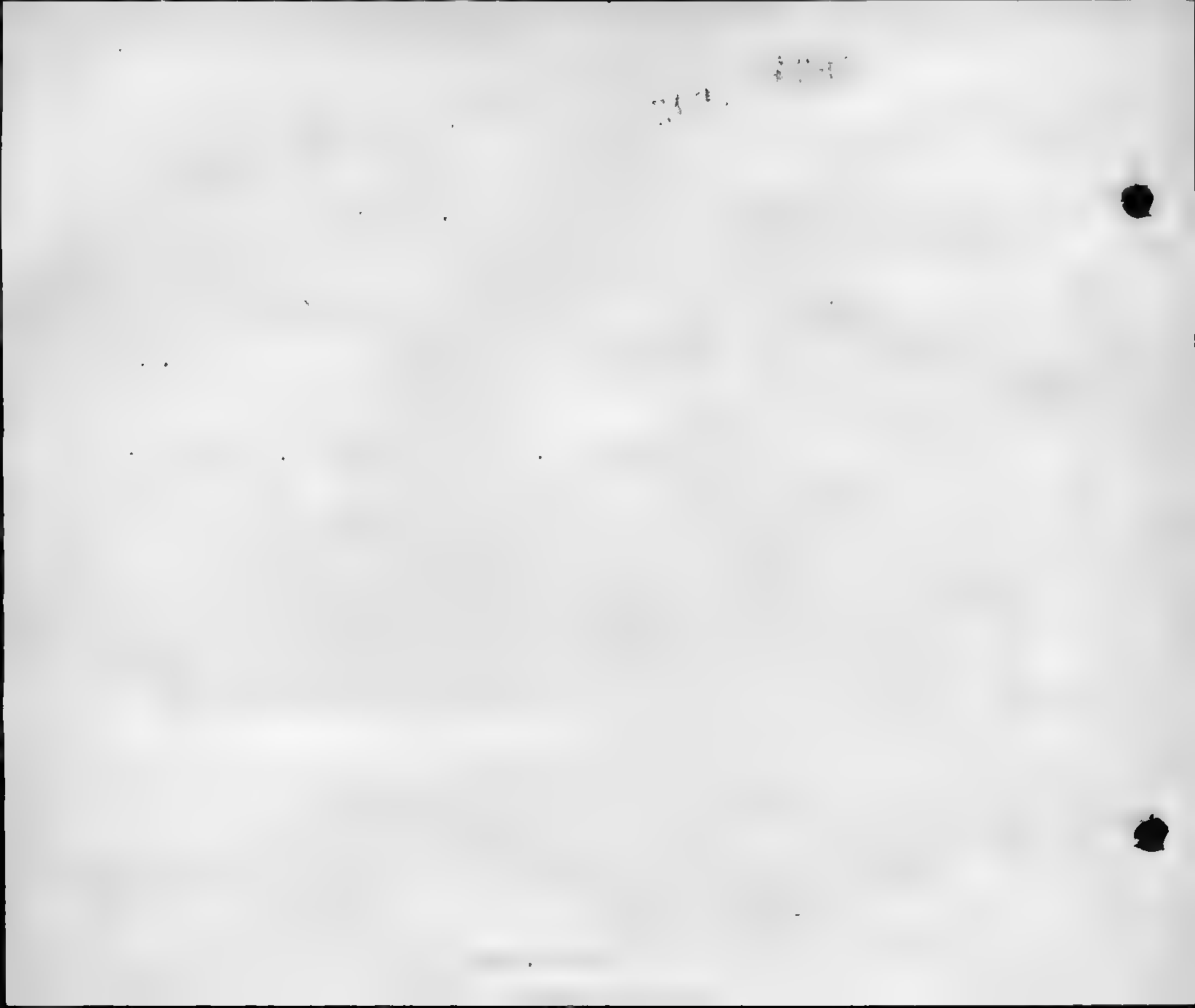
CERTIFICATE OF DEATH

1694

01674

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>House-In-Pines Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>5 N. Prospect Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Wellner</u> First Middle Last		4. DATE OF DEATH <u>February 4 1961</u> Month Day Year	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 8, 1874</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> yrs.		9. AGE (in years last birthday) <u>86</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet-Metal Construction</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>212-03-0493</u> 17. INFORMANT <u>Mrs William Suchting-5 N. Prospect Ave: 28 Md</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>443X</u> DUE TO (b) <u>Chronic Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>2021</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>9-26-1949</u> to <u>2-4-1961</u> , that (I) (we) last saw the deceased alive on <u>2-3-1961</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William K. Gollay, M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>William K. Gollay, M.D.</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>6509 Frederick Ave. Baltimore 28, Md.</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Burial 2-7-1961</u> REMOVAL (Specify)		23c. NAME OF CEMETERY OR CREMATORY <u>Western</u> 23d. LOCATION (City, town or county) <u>Baltimore</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Hall</u> ADDRESS <u>301 Frederick Rd.-28-</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 8 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles E. Hays</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



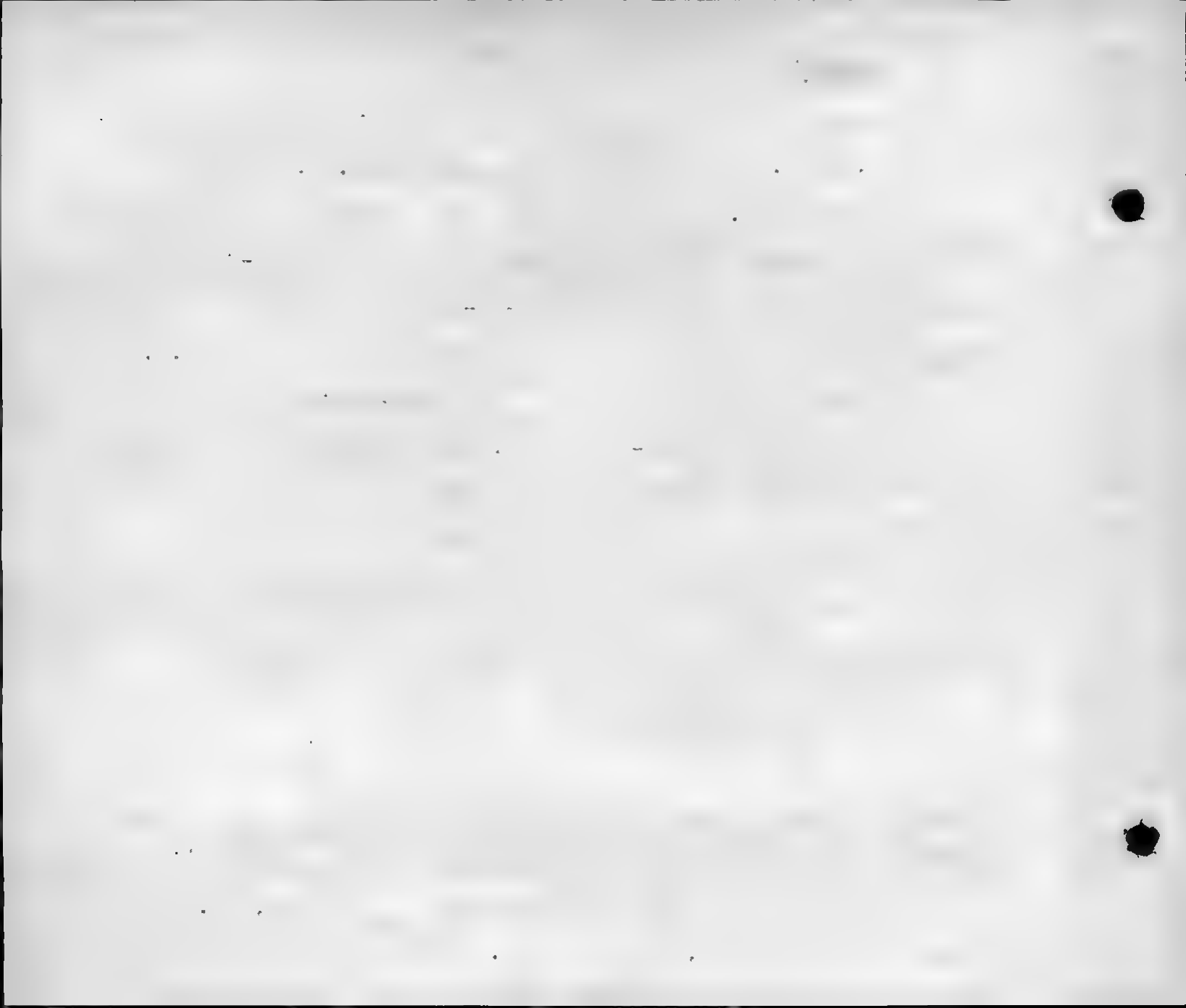
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part of this certificate is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
01675											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Essex, Balto. 21,				c. LENGTH OF STAY IN 1b ? yrs				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex, Balto. 21,			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 300 George Ave.				d. STREET ADDRESS 300 George				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Herbert Grason Wheeler				4. DATE OF DEATH Month 2-24-61 Day 19 Year 19							
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-18-1895		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min. 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm manager				10b. KIND OF BUSINESS OR INDUSTRY farm				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Wheeler				14. MOTHER'S MAIDEN NAME Margaret Ford							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 212-32-3299				17. INFORMANT Mrs. Edvena Wheeler, Address above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 20.1 DUE TO Cornary Occlusion Conditions, if any, which gave rise to immediate cause (b) A-S-C-V-Disease (c), stating the underlying cause last. DUE TO (c) A-S-C-V-Disease				INTERVAL BETWEEN ONSET AND DEATH 4 20.1							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE M.B. Davis				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 2/25/61			
EXAMINER'S NAME (Type) M.B. DAVIS MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-27-61				22c. NAME OF CEMETERY OR CREMATORY Fairview Methodist			
22d. LOCATION (City, town, or county) (State) Phoenix, Md.											
23. FUNERAL DIRECTOR Brooks Funeral Service, Towson 4, Md.				ADDRESS				24a. REC'D BY REGISTRAR MAR 1 '61			
24b. REGISTRAR'S SIGNATURE Arthur S. Huns											



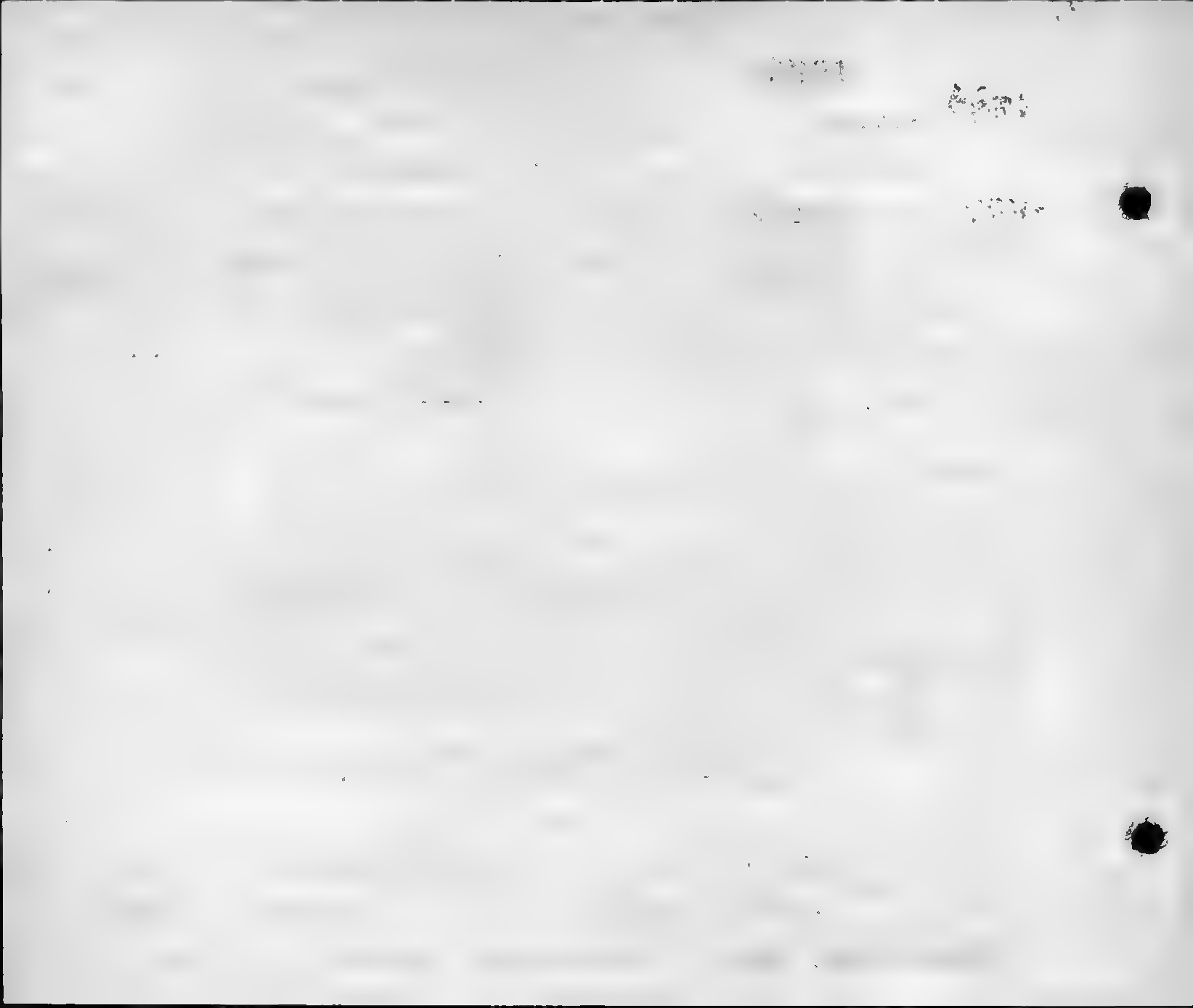
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

<div> <div>1</div> <div> <div>1696</div> <div> <div>1676</div> <div>1676</div> </div> </div> </div>													
<div> <div> <div>1</div> <div> <div>1696</div> <div> <div>1676</div> <div>1676</div> </div> </div> </div> </div>													
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>22 Dungarrie Road</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Catonsville</u> d. STREET ADDRESS <u>22 Dungarrie Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Louise</u> Last <u>White</u>				4. DATE OF DEATH Month <u>February</u> Day <u>15</u> Year <u>19 61</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 10, 1876</u>		9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Joseph A. Davis</u>				14. MOTHER'S MAIDEN NAME <u>Maguire</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> (b) <u>Myocarditis</u> (c) <u>Hypertensive Cardio-Vascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u> </u>													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-21-57</u> to <u>2-15</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>2-15</u> , 19 <u>61</u> and that death occurred at <u>5:30a</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>George E. Urban</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-17-61</u>							
22c. PHYSICIAN'S NAME (Type) <u>George E. Urban M.D.</u>				22d. ADDRESS <u>805 Frederick Ave. Balto. 28,</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-18-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) <u>Baltimore</u>		(State) <u>Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>MacNeil Sam Home</u>				ADDRESS <u>301 Frederick Road</u>		25a. REC'D BY REGISTRAR <u>FEB 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Christina S. House</u>					

VR A15 (4)
15M 9/60



1697

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer Park Road		d. STREET ADDRESS Deer Park Road	
3. NAME OF DECEASED (Type or print) First Edith Middle Whitley Last Whitley		4. DATE OF DEATH Month February Day 8 Year 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1866
9. AGE (In years last birthday) yrs 94		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME William Whitley		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Mrs. Cecelia White, Deer Park Road		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-vascular Disease 422 DUE TO (b) Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 4 days 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 4, 1961 , to February 8, 1961 , that I last saw the deceased alive on February 8, 1961 , and that death occurred at 7:00 P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Charles E. McWilliams M.D. Reisterstown, Maryland PHYSICIAN'S NAME (Type) Charles E. McWilliams			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-11-61	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE FEB 10 '61	
24b. REGISTRAR'S SIGNATURE Charles E. McWilliams			

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be reviewed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1698

1698

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01678

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
c. LENGTH OF STAY IN 1b 1 mo. 22 da.		d. STREET ADDRESS 405 Mt. Holly Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood St. Tr. School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Adair Middle Denise Last Wiley		4. DATE OF DEATH February 27 1961 Month Day Year	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/28/60
9. AGE (In years last birthday) 4		10. IF UNDER 1 YEAR Months 4 Days 29 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Avon Coleman		14. MOTHER'S MAIDEN NAME Phyllis Wiley, 405 Mt. Holly Street	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rosewood Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1) Hydrocephalus, moderate 3 4 4 X DUE TO 2) Otitis media, bilateral Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. 3) Status following Shigella infection DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that death occurred at 1:15 PM , from the causes and on the date stated above			
22a. SIGNATURE Pete W. Rieckert		22b. DATE SIGNED 2-27-61	
22c. PHYSICIAN'S NAME (Type) Pete W. Rieckert		22d. ADDRESS 4307 Mainfield Ave, Balto 14	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF March 2 1961	
23c. NAME OF CEMETERY OR CREMATORY Rosewood		23d. LOCATION (City, town, or county) (State) Owings Mills Md	
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Elmer, Sons Restuctors Md		25a. REC'D BY REGISTRAR MAR 6 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur L. Kane	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

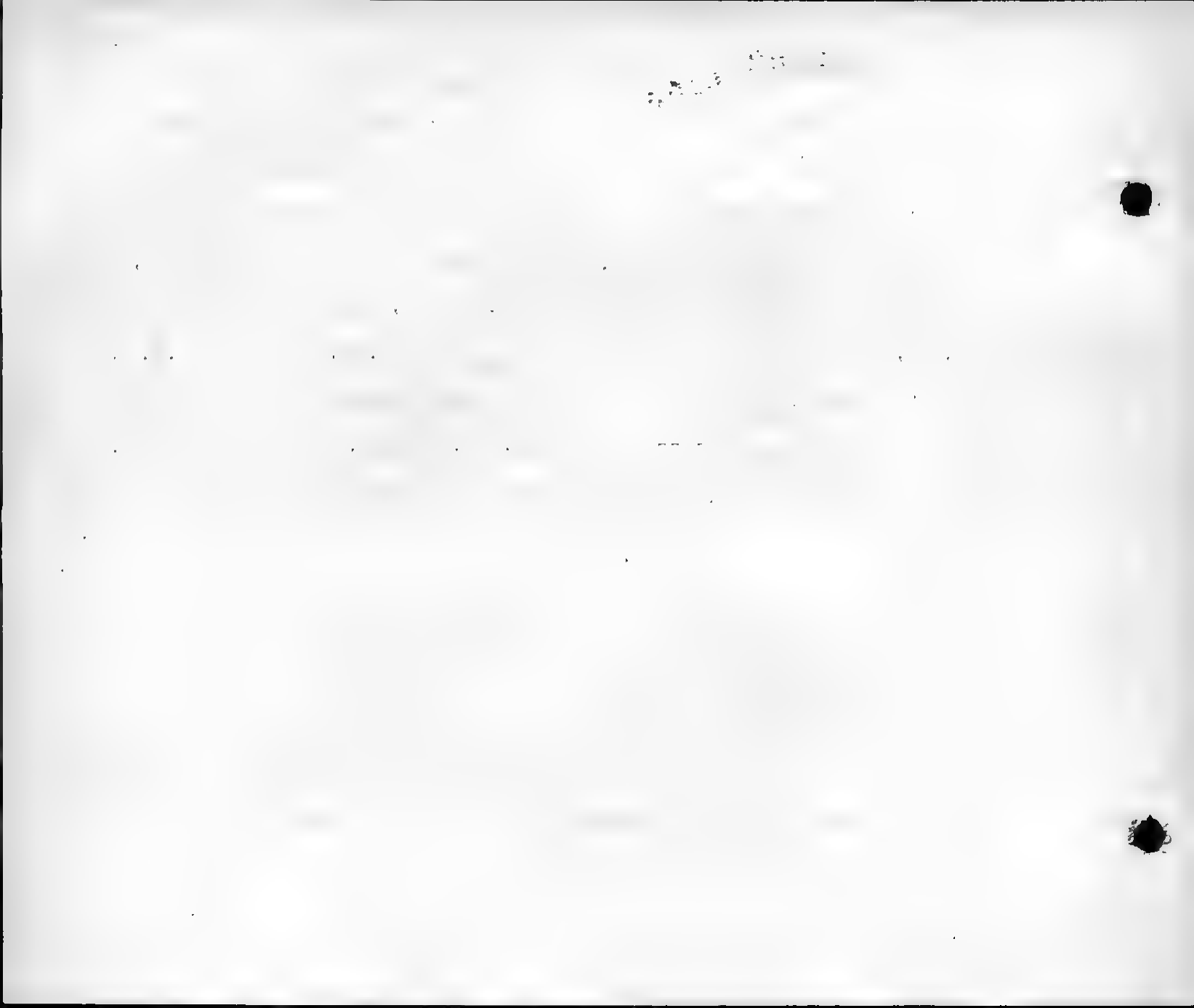
01679

1699

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville c. LENGTH OF STAY IN 1b XXXX Pikesville d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4735 Old Court Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXX Pikesville 8, Maryland d. STREET ADDRESS 4735 Old Court Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ilia Middle H. Last Williams		4. DATE OF DEATH Month February Day 7 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 21, 1892
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR: Months 68 Days 68 Hours 68 Min. 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At. Home		10b. KIND OF BUSINESS OR INDUSTRY Eure. N. C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua Harrell		14. MOTHER'S MAIDEN NAME Sarah Horton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ----		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Arthur C. Mather, 4735 Old Court Rd.		Address 4735 Old Court Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 443X DUE TO Hypertensive C.V. disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Hypertrophic Arteriosclerosis - General - some		INTERVAL BETWEEN ONSET AND DEATH 5 days 12 years 12 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1948 to Feb - 7, 1961 , that I last saw the deceased alive on Feb 7, 1961 , and that death occurred at 5A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas E. Wheeler M.D.		ADDRESS (Street, city or town, state) Randallstown - Md 2/7/61	
DATE SIGNED 2/7/61		DATE SIGNED 2/7/61	
PHYSICIAN'S NAME (Type) Ellsworth Armacost		ADDRESS Ellsworth Armacost-4600 Liberty Heights Ave.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-8-61	
22c. NAME OF CEMETERY OR CREMATORY Ahaskie, North Carolina		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		24a. REC'D BY REGISTRAR FEB 10 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		24c. REGISTRAR'S SIGNATURE	



1700

CERTIFICATE OF DEATH

Reg. Dist. No.

01680

V5 A15 (4)
15M 10/57



1701

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

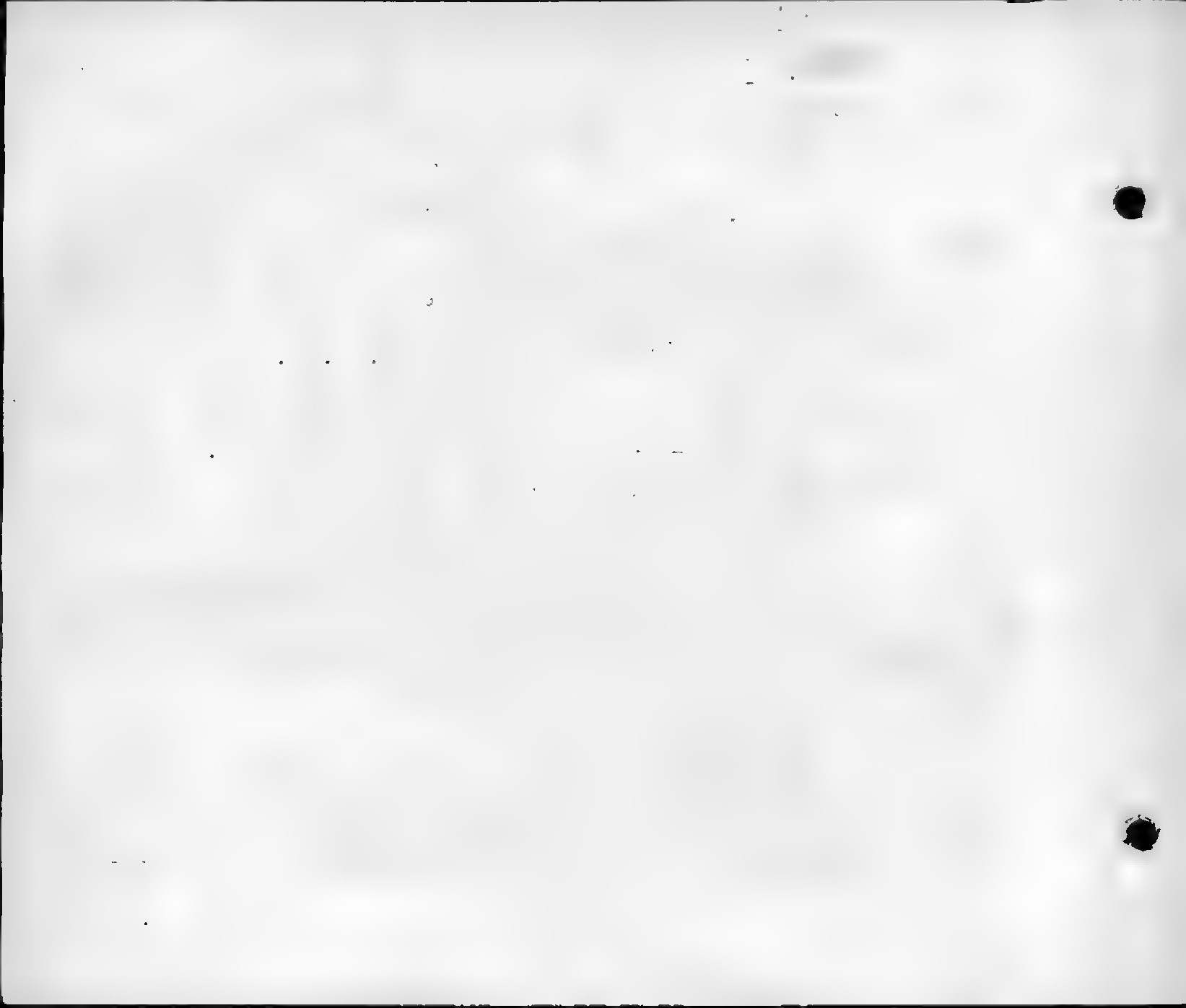
Reg. Dist. No.

01681

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FULLERTON * BALTOO c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4500 Ridge Rd.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FULLERTON Baito 6 Md d. STREET ADDRESS 4500 RIDGE ROAD e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH EDWARD WINKLER		4. DATE OF DEATH Month Day Year Feb 5 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 July 1893
9. AGE (In years last birthday) 67 yes		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) builder		10b. KIND OF BUSINESS OR INDUSTRY Constr	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank Winkler		14. MOTHER'S MAIDEN NAME Katherine Klein	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 211-34-4847	
17. INFORMANT Francis Winkler		Address 4500 Ridge Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH minutes undet	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John C. Hyle		DATE SIGNED 2-5-61	
EXAMINER'S NAME (Type) John C Hyle MD		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-8-1961	
22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Sassahn Funeral Home 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE FEB 8 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1702 CERTIFICATE OF DEATH 01682

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>B1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>600 Chulmleigh Rd.</u>		d. STREET ADDRESS <u>600 Chulmleigh Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Estelle</u> Middle <u>T.</u> Last <u>Wolfe</u>		4. DATE OF DEATH Month <u>February</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1872</u>
9. AGE (In years last birthday) <u>88</u> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>16</u> Hours <u>19</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>hostess</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>funeral home</u>	
11. BIRTHPLACE (State or foreign country) <u>Swan, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Shadrach Tipton</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Ann Leaf</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Mrs Helen Wilson</u>		Address <u>600 Chulmleigh Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u> DUE TO <u>ARTERIOSCLEROTIC CARDIOVASCULAR</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>RENAL DISEASE WITH HYPERTENSION</u> (c) <u>2 YRS.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 MOS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>FEB 29</u> , 19 <u>60</u> to <u>FEB 16</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>FEB 15</u> , 19 <u>61</u> , and that death occurred at <u>6AM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>T. C. Siwinski</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Thaddeus C. Siwinski, M.D.</u>		22d. ADDRESS <u>206 W. Pennsylvania Avenue, Towson 4,</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 18, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Black Rock Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Butler, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>		25. REC'D BY REGISTRAR <u>3000 E. Baltimore St.</u>	
25a. REGISTRAR'S SIGNATURE <u>DATE FEB 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

200

1951



CERTIFICATE OF DEATH

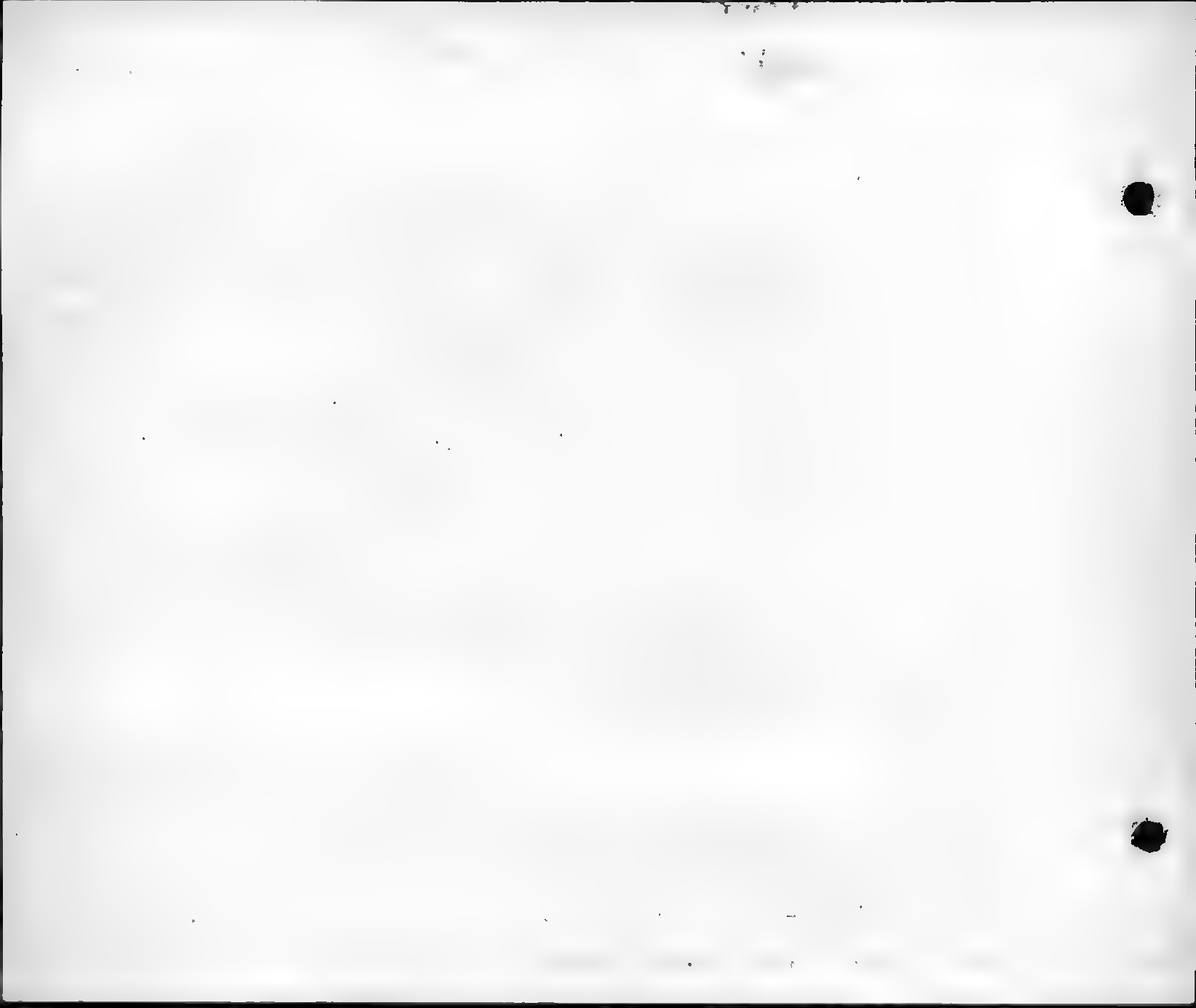
Reg. Dist. No. 01683

1703

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON - Md</u>		c. LENGTH OF STAY IN 1b <u>6 mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Men's Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELIZA</u> Middle <u>McCauley</u> Last <u>Woods</u>		4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-1875</u>
9. AGE (In years last birthday) <u>85</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUSICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Francis Woods</u>		14. MOTHER'S MAIDEN NAME <u>Mabel Montgomery Couler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>H.F. Haight 724</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma - bowel</u> DUE TO (b) <u>153-7</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>16 mo</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal Cardio-Vascular accident</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 8, 1959</u> to <u>February 9, 1961</u> , that I last saw the deceased alive on <u>February 8, 1961</u> , and that death occurred at <u>8:00 a.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Cook, Inc.</u>		DATE SIGNED <u>February 9, 1961</u>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-11-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore 2, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>Feb 10 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1704

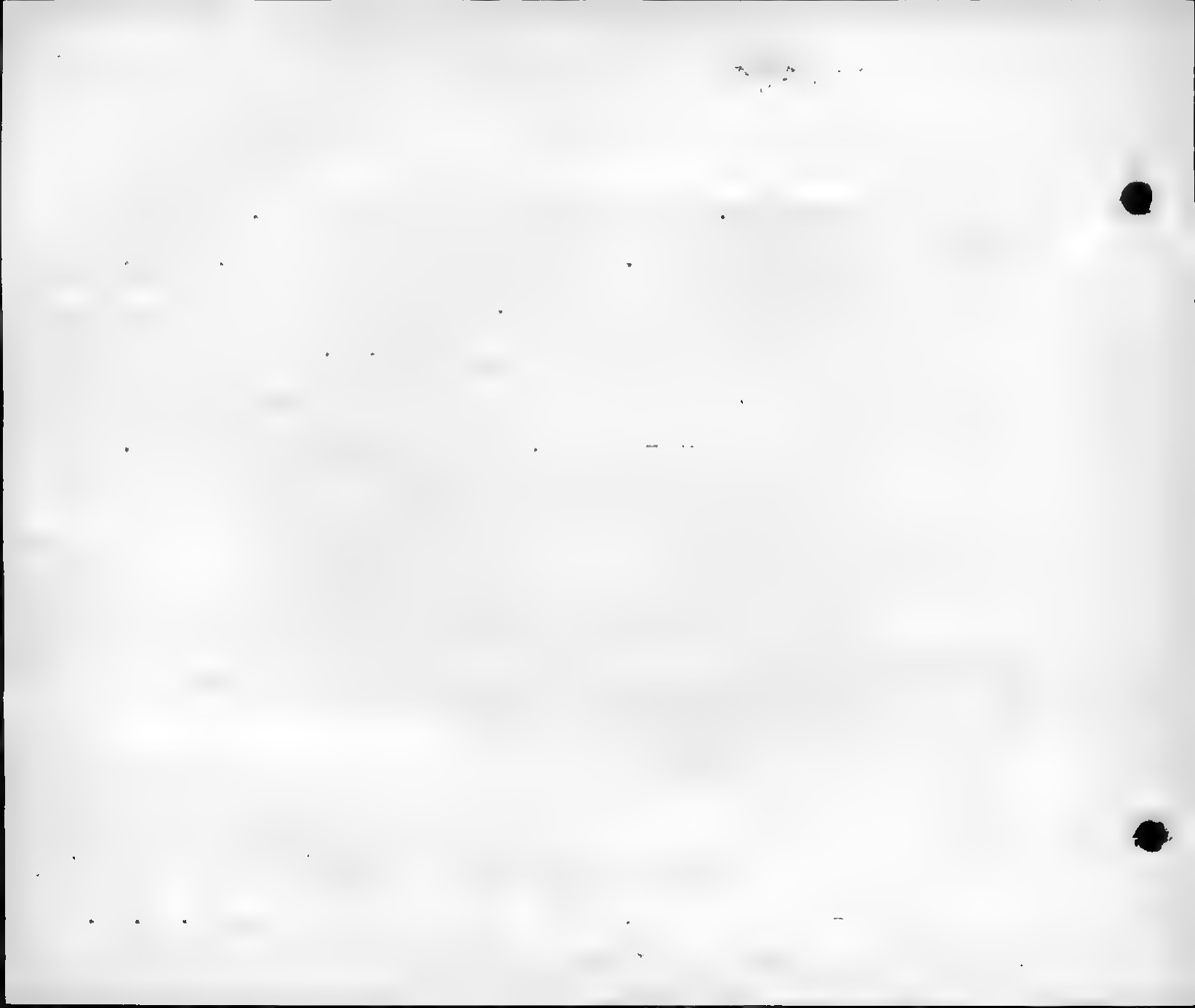
CERTIFICATE OF DEATH

01684

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6905 Linden Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>J.</u> Last <u>Worthington</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>29</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 22, 1892</u>	
9. AGE (in years last birthday) <u>69</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brewery</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Thomas Worthington</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lannahan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-9323</u>		17. INFORMANT <u>Mrs. Anna Worthington</u> Address <u>6905 Linden Ave. 6</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of Pancreatic Cyst</u> DUE TO <u>Chronic Pancreatic Disease</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>Many yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>Arteriosclerotic Cardiovascular Disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a</u> m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1954</u> to <u>2-28</u> , 1961, that (I) (we) last saw the deceased alive on <u>2-23</u> , 1961, and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Max R. English</u> M.D.				22b. DATE SIGNED <u>July 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Max R. English M.D.</u>				22d. ADDRESS <u>5713 Belair Rd Balto</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-4-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>		23d. LOCATION (City, town, or county) (State) <u>Fullerton, Balto. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lawrence Funeral Home</u> ADDRESS <u>7401 Belair Rd</u>				25a. REC'D BY REGISTRAR <u> </u> DATE <u>MAR 6 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

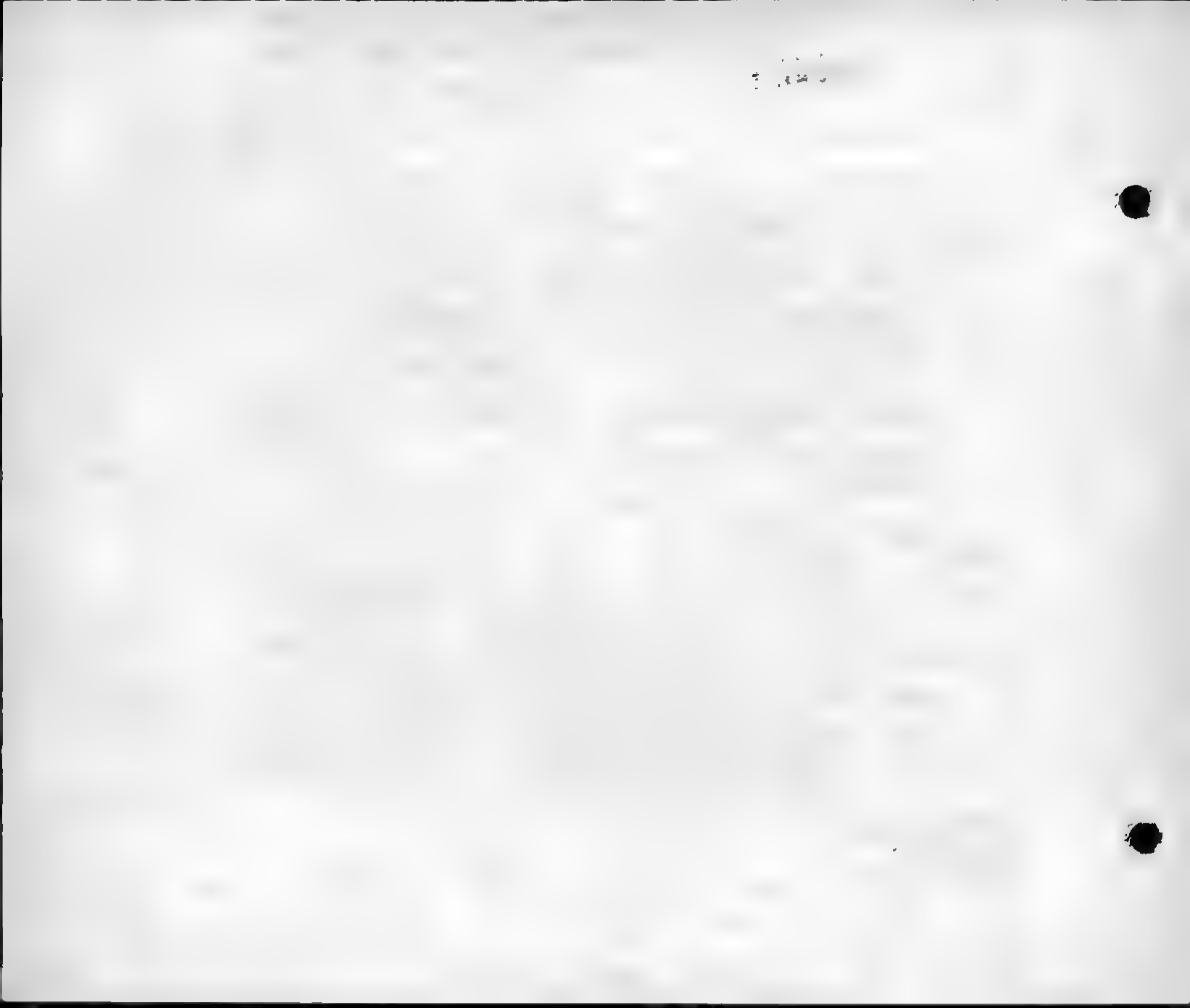
Reg. Dist. No. **01685**

1705

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balt.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 404 Strights Rd.				d. STREET ADDRESS 1 404 Strights Rd.			
3. NAME OF DECEASED (Type or print) First ANNIE Middle BARBARA Last WRIGHT				4. DATE OF DEATH Month 2 Day 3 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1903	9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME J. Zametzer				14. MOTHER'S MAIDEN NAME Sarah J.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Elroy Wright (Same as above) Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial insuff. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 min. 11 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C. Ellons				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2-3-61	
EXAMINER'S NAME (Type) Jack C. Ellons				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-61		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly				ADDRESS 418 Eastern Club		24a. REC'D BY REGISTRAR FEB 6 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



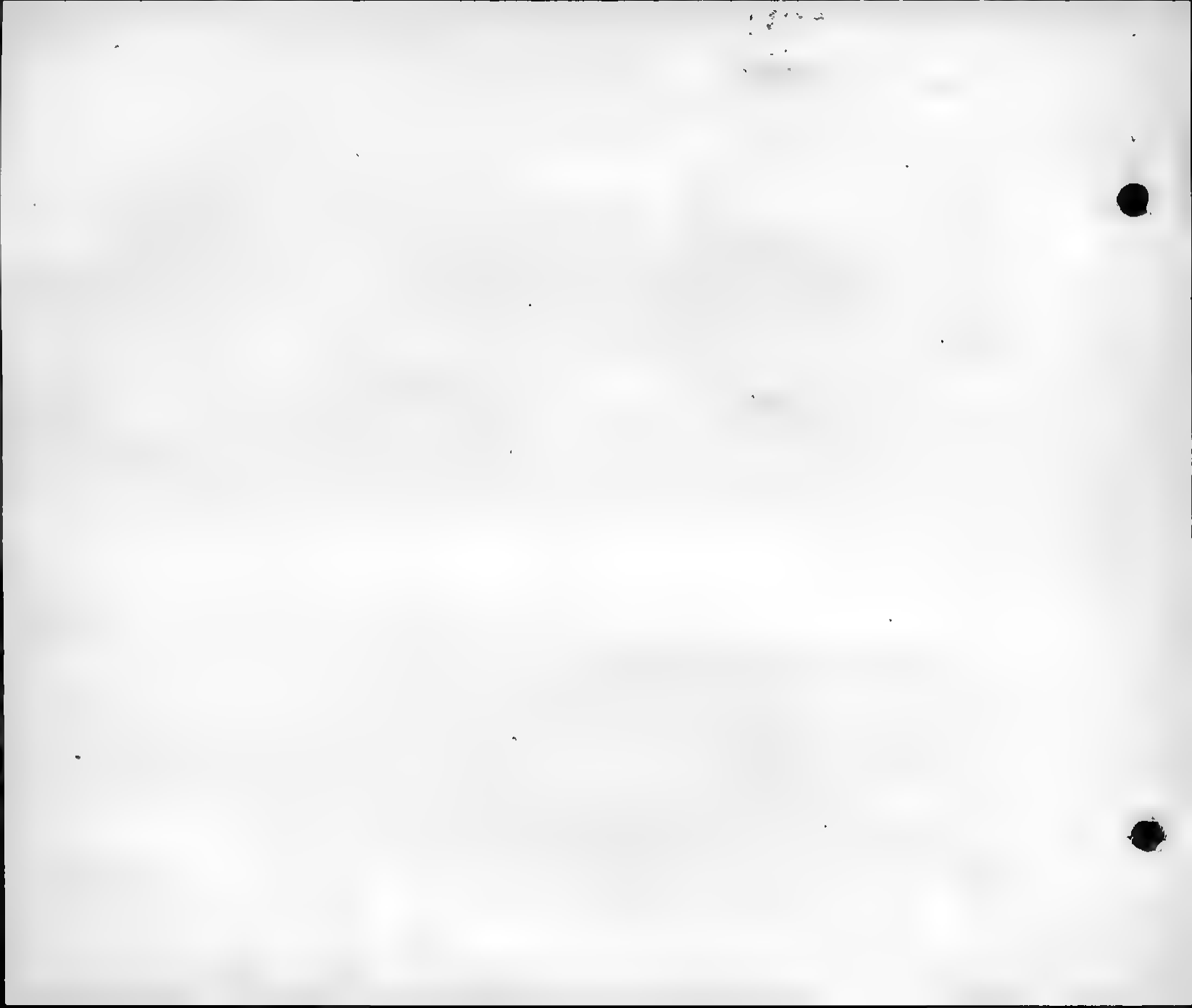
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
2
1706
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01686

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <i>Catonsville</i> c. LENGTH OF STAY IN 1b <i>1706</i>		2 USUAL RESIDENCE (Where deceased lived: If institution, Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Boies</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <i>5408 Channing Rd.</i>		d. STREET ADDRESS <i>5408 Channing Rd.</i>	
3 NAME OF DECEASED (Type or print) First Middle Last <i>Annie S. Wright</i>		4. DATE OF DEATH Month Day Year <i>Feb. 2, 1961</i> 19	
5 SEX <i>Female</i>	6. COLOR OR RACE <i>W.</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 27, 1876</i>
9 AGE (In years less birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H. W.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>
12. CITIZEN OF WHAT COUNTRY? <i>W. S. A.</i>		13. FATHER'S NAME <i>Mays</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>422-1</i>		17 INFORMANT <i>Mrs. Ellsworth Helleary</i> Address <i>5408 Channing Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intense acute coronary disease</i> 422.1 DUE TO <i>disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p m <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <i>March 12, 1933</i> to <i>Feb 2, 1961</i> , that (I) <i>(was)</i> last saw the deceased alive on <i>May 11, 1961</i> and that death occurred at <i>23-M</i> , from the causes and on the date stated above			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <i>2-3-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>HARRY L. Knipp M.D.</i>		22d. ADDRESS <i>4116 Edmondson Ave Baltimore</i>	
23a. BURIAL, CREMATION, REMOVAL, (Specify)	23b. DATE THEREOF <i>Feb. 4/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Private Burial Ground</i>	23d. LOCATION (City, town, or county) (State) <i>Shipsman, Virginia</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. F. L. 4181 Edmondson Ave</i>		25a. REC'D BY REGISTRAR <i>Feb 6 '61</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01687

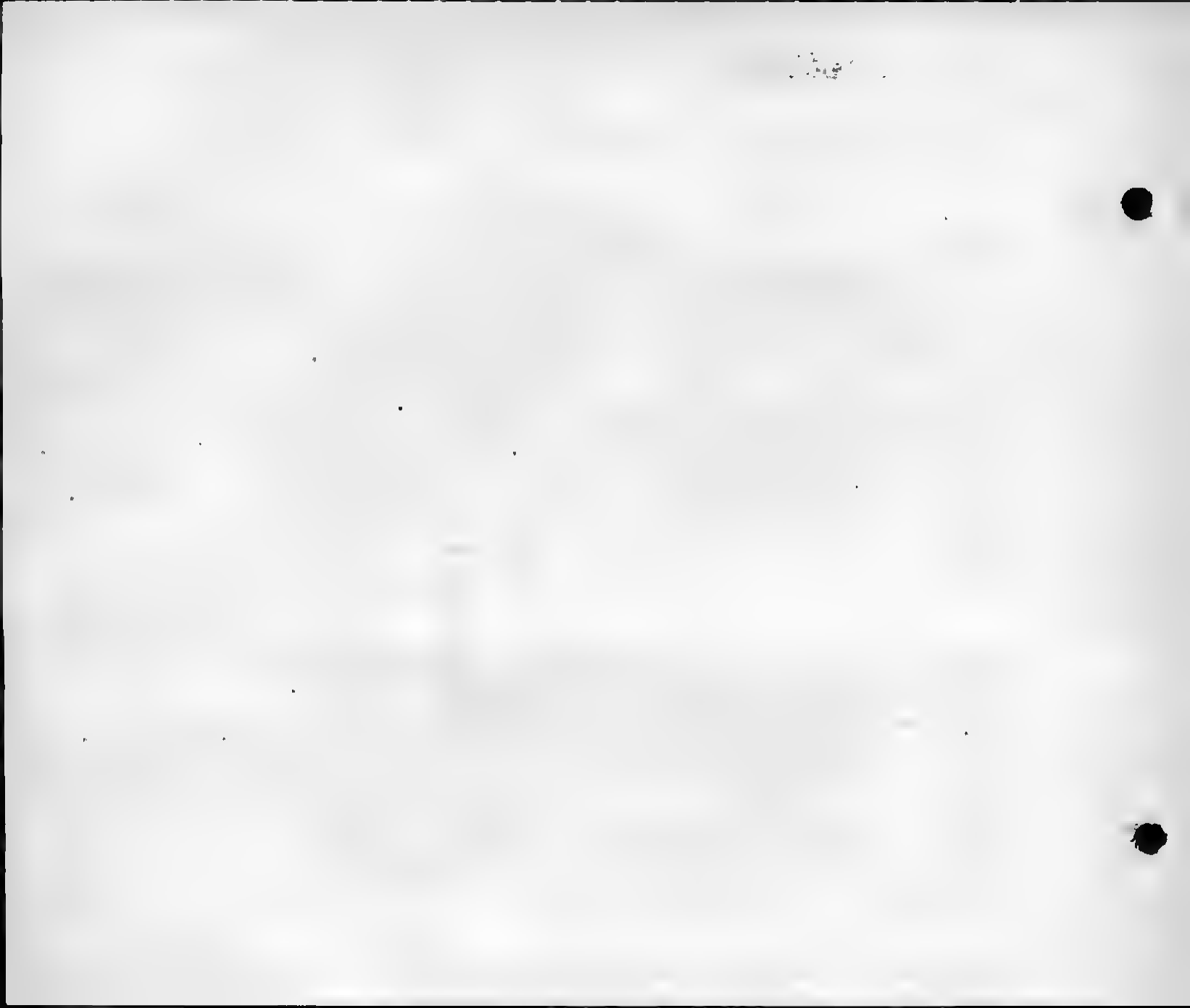
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (White Hall)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (White Hall)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>White Hall Road</u>		d. STREET ADDRESS <u>Shawsville</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Donald Garrison Wright</u>		4. DATE OF DEATH Month Day Year <u>Feb. 20 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9, 1939</u>
9. AGE (In years last birthday) <u>21</u> yrs.		IF UNDER 1 YEAR Months Days <u>10 11</u>	IF UNDER 24 HRS. Hours Min. <u>10 11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Feed Business</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>B. Donald Wright</u>		14. MOTHER'S MAIDEN NAME <u>Mabel B. Garrison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes 1957</u>		16. SOCIAL SECURITY NO. <u>218-38-3786</u>	
17. INFORMANT <u>B. Donald Wright</u>		Address <u>White Hall, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burned to death</u> <u>819. X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? <u>YES</u> <input type="checkbox"/> <u>NO</u> <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Truck he was driving struck an electric pole and a falling wire set fire to his truck.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>2:40</u> p.m. <u>2/20/61</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
20f. (City or town) <u>White Hall, Balto. Md.</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>		22d. LOCATION (City, town, or county) (State) <u>Madonna Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Rusty</u>		24a. REC'D BY REGISTRAR <u>FEB 24 '61</u>	
ADDRESS <u>Jarrettsville, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1708

01688

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN MD 5 YRS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 206 MARYLAND AVE		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MD b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON d. STREET ADDRESS 206 MD. AVE	
3. NAME OF DECEASED (Type or print) KENNETH CHARLES YOUNKER SEX M COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 1-3-13 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) 48 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS		4. DATE OF DEATH FEB 25 1961 5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) WELDER 10b. KIND OF BUSINESS OR INDUSTRY TOOL 11. BIRTHPLACE (State or foreign country) MD. 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES LEE YOUNKER 14. MOTHER'S MAIDEN NAME McCOMBS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES NAT. GUARD 16. SOCIAL SECURITY NO 17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 120 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/25/61 DEPUTY MEDICAL EXAMINER 206 YORK RD Fincroon md. Address (Street, city, town, or county)	
ACTUAL SIGNATURE William A. Pillsbury EXAMINER'S NAME (Type) William A. Pillsbury		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF MAR 1, 1961 22c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial Gardens 22d. LOCATION (City, town, or county) (State) Tockeysville, MD.	
23. FUNERAL DIRECTOR John Burns' Sons, Towson, Md. ADDRESS		24a. REC'D BY REGISTRAR MAR 7 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH
1 HR.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01689											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 62 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills d. STREET ADDRESS Deer Park Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CHARLES E. ZEIGLER				4. DATE OF DEATH FEBRUARY 20 19 61				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 8/20/88 9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Farm				11. BIRTHPLACE (County & State, or foreign country) Baltimore County, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Zeigler				14. MOTHER'S MAIDEN NAME Hannah Fuller							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WW I				16. SOCIAL SECURITY NO. 217-03-7353				17. INFORMANT Clin. Rec. VAH, Balto. Md. Fort Howard Division Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 493X DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MUCOUS ADENOCARCINOMA BLADDER DUE TO (c) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH 1 Day											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that the (this hospital) attended the deceased from 12/20/1960 to 2/20/1961 that he (we) last saw the deceased alive on 2/20/1961 , and that death occurred at 1:25 PM from the causes and on the date stated above.											
22a. SIGNATURE Donald W. Stewart M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 2/20/61											
22c. PHYSICIAN'S NAME (Type) DONALD W. STEWART, M.D. 22d. ADDRESS VAH, BALTO. MD. FORT HOWARD DIVISION											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2-23-61 23c. NAME OF CEMETERY OR CREMATORY Wards Chapel Cemetery 23d. LOCATION (City, town or county) (State) Baltimore County, Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE Weer & Haight Funeral Dir. ADDRESS Sykesville, Md. 25a. REC'D BY REGISTRAR FEB 23 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hana											

1900

(M)

(I)

Wm. A. Hays, Secy. of War, Washington, D.C.

1

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01690

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 18 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		d. STREET ADDRESS Berrymans Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Blanche E. Zimmerman		First		Middle		Last		4. DATE OF DEATH Month Feb. Day 17 Year 1961		5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 3, 1885		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jacob Mays		14. MOTHER'S MAIDEN NAME Sarah Shetler		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Frank Jones, Berrymans Lane, Reisterstown, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction DUE TO 153.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ca. of Colon DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 1 1/2 yrs.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none		20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)					
21. I certify that (I) (physician) attended the deceased from 8-27-44 19 to 2-17-61 19, that (I) (physician) last saw the deceased alive on 2-16-61 19, and that death occurred at 6 A.M. from the causes and on the date stated above.		22a. SIGNATURE D. D. Caples		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-17-61		22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		22d. ADDRESS 6 Hanover Rd., Reisterstown, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF 2-20-61		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Pickens & Sons		ADDRESS Baltimore 17, Md		25a. REC'D BY REGISTRAR FEB 21 '61		25b. REGISTRAR'S SIGNATURE William J. H. H.																	

11/18/11

STATE OF TEXAS

1810

County of ...
State of Texas

County of ...
State of Texas

Know all men by these presents, that ...

for and to the use of ...

for and to the use of ...

and

and

to have and to hold unto the said ...

to have and to hold unto the said ...



Witness my hand and seal of office this ... day of ... 18...

Notary Public for the State of Texas

My commission expires the ... day of ... 18...

Notary Public for the State of Texas

Witness my hand and seal of office this ... day of ... 18...

Notary Public for the State of Texas

My commission expires the ... day of ... 18...

My commission expires the ... day of ... 18...